

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 retained by the hospital or attending physician.

DHMH-16 25M  
(VRA 15, 4) 1/79TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 2 0 4 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Merl William ADAMS				2a. DATE OF DEATH MONTH DAY YEAR September 17, 1980		2b. HOUR 11:25 P.M.	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 29 1902		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10 CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY Refrigeration	
13a. STATE Maryland		13b. COUNTY Balto.		13c. CITY OR TOWN Edgemere		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Albert Lee Adams		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie D. Reed		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			
16b. SOCIAL SECURITY NO 213-07-8010		17 INFORMANT Merl A. Adams ADDRESS 7423 Bayfront Rd. Balto. Md. 21219					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary Arrest 1629 DUE TO, OR AS A CONSEQUENCE OF Large Cell Carcinoma of the (b) Lung with Metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 15, 1980, to September 17, 1980, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on September 17, 1980, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <del>not</del> view the body after death.							
22b. SIGNATURE Marcia Good				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/17/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marcia Good M.D.				22e. ADDRESS 9000 Franklin Square Drive 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/22/1980		23c. NAME OF CEMETERY OR CREMATORY Meadowridge		23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey Howard Md.	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.				25a. DATE REC'D. BY REGISTRAR SEP 22 1980		25b. REGISTRAR'S SIGNATURE [Signature]	
7922 Wise Ave. Dundalk, Md. 21222							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										80		22041	
1. FOR STATE REGISTRAR				REG. NO.									
1 DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
SARAH KATHLEEN ADDICKS								9/07/80				3:32 AM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR		8 UNDER 24 HRS			
FEMALE		WHITE		9 MONTH DAY YEAR 09 05 80				MONTHS 2		DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH	
Towson				USA								BALTIMORE COUNTY MD.	
10 CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON, MD.				GBMC-6/01 N. CHARLES ST.				None				None	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?	
Maryland								Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Kenneth W. Addicks, Jr.				Mary Kathleen Hennessy									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO				17 INFORMANT ADDRESS					
No				None				Kenneth W. Addicks, Jr.				Same	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) MECONIUM ASPIRATION PNEUMONIA													
DUE TO, OR AS A CONSEQUENCE OF													
(b) POSSIBLE PERSISTENT FETAL CIRCULATION													
DUE TO, OR AS A CONSEQUENCE OF													
(c) POSS. COMPLICATION OF (A) & B RENAL FAILURE & CHF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/05 19 80, to 9/07 19 80, that (I) (we) lost saw the deceased alive on 9/07 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				22c. DATE SIGNED					
[Signature]				MD				9/07/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
WILLIAM E. SCHWARTZ				1900 E. NORTHERN PKY, BALTO, MD, 21239									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION	
Burial				9/9/80				New Cathedral				Balto., COUNTY STATE Md.	
24 FUNERAL DIRECTOR NAME				24b. ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE	
Henry W. Jenkins & Sons Co.				4905 York Road Balto., Md. 21212				SEP 9 1980				[Signature]	



100 E. BROADWAY, NEW YORK 10003  
JAMES H. HARRIS, JR.  
WIFE  
2 DAYS  
BALTIMORE COUNTY  
None  
None  
6115 Alta Avenue  
Baltimore  
Maryland  
Kenneth W. Addicks, Jr.  
Mary Kathleen Addicks  
None  
None  
Kenneth W. Addicks, Jr.  
Same

POSSIBLE PERSISTENT PERIL CIRCULATION  
POST. COMPLICATION OF C.B. REIN. FAILURE

X

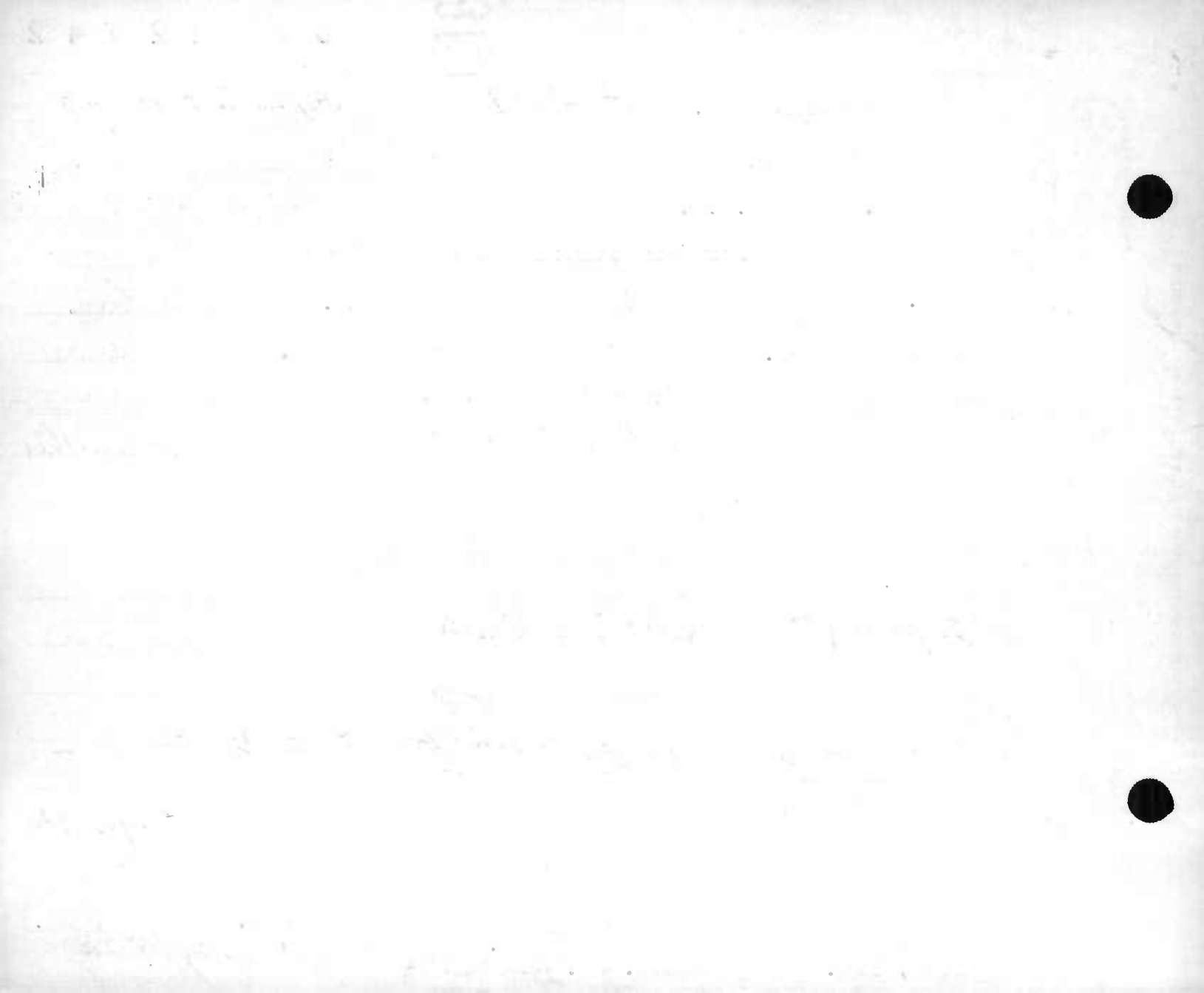
9/8/80 New Cathedral  
Henry W. Jenkins & Sons Co.  
Baltimore, Md. 21212  
Baltimore, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8022042	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST GLADYS		MIDDLE L.		LAST Affeld		2a. DATE OF DEATH MONTH DAY YEAR September 8 1980		2b. HOUR 7:30 M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan 22 1920		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Newspaper			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Tenn.				13b. COUNTY		13c. CITY OR TOWN Erwin		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 3 Box 188B Erwin Tenn.	
14. FATHER'S NAME FIRST MIDDLE LAST James N. Lewis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laretta E. Riddle							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 411-18-6259		17. INFORMANT ADDRESS Robt. M. Affeld (husband) same address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Glioblastoma 1919 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION 2 January 1980		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Glioblastoma				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (the hospital) attended the deceased from 27 August 80 to 8 Sept 80, that (I) (we) most saw the deceased alive on 8 Sept 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE Walter T. Rees		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8 Sept 1980			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER T. REES				22e. ADDRESS Moulton Md 21111							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/11/80		23c. NAME OF CEMETERY OR CREMATORY Holly Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.					
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.						9705 Belair Rd. Balto. Md. 21236		25. DATE REC'D. BY REGISTRAR SEP 9 1980		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 2 0 4 3			
1. FOR STATE REGISTRAR XC 16 020 644				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) TROY JASPER ALLEY				2a. DATE OF DEATH 9 11 80		2b. HOUR 9:10 P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 8 7 08		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) V. A. MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND				13b. CITY OR TOWN ANN ARUNDEL SEVERN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William L. C. Alley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sara F. Coleman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WWII 244 05 1482		17. INFORMANT ADDRESS CLINICAL RECORDS, VAMC, FORT HOWARD, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC BLADDER CARCINOMA 1889 DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 8/1 19 80, to 9/11 19 80, that (we) lost saw the deceased alive on 9/11 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature] M.D.				DEGREE		22c. DATE SIGNED 9/11/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LUIS A. CISNEROS, M. D.				22e. ADDRESS V. A. MEDICAL CENTER, FORT HOWARD, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 15 Sept. 80		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, AA, Md.	
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, Md.				25a. DATE REC'D. BY REGISTRAR SEP 16 1980		25b. REGISTRAR'S SIGNATURE [Signature]	

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2/11/80

SEP 18 1980

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 0 4 4

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>BLANCHE M ALLISON</b> <i>BLANCHE Marie Allison</i>		2a. DATE OF DEATH MONTH DAY YEAR <b>SEPT. 12, 1980</b>		2b. HOUR P <b>7:15</b> M	
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 6, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Towson</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>551 Brook Road 21204</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ferdinand Barnes</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Lennon</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT ADDRESS <b>Mr. Raymond J. Woolford Balt, Md 21204</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>RECURRENT PULMONARY EMBOLI</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PRIMARY THROMBOCYTOSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>PNEUMONIA, CONGESTIVE HEART FAILURE, GASTRIC ULCER</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>AUG. 8</b> 19 <b>80</b> , to <b>SEPT. 12</b> 19 <b>80</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>SEPT. 12</b> 19 <b>80</b> , and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (not) view the body after death.					
22b. SIGNATURE <i>Dr. Kalabia</i>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>9/12/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. KALABIA</b>		22e. ADDRESS <b>7620 YORK RD. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>9/13/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Security Process</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Balt., Md.</b>		23e. DATE REC'D BY REGISTRAR <b>SEP 15 1980</b>		23f. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
24. FUNERAL DIRECTOR NAME <b>MacNabb Funeral Home</b>		ADDRESS <b>Catonsville, Md.</b>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



SEP 12 1980

*Handwritten signature*

ALY JULIA S 4251A

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate is to be retained by the hospital or attending physician for 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then the certificate should be filed in Baltimore in calendar pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP  
DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 22045

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Julia S. ALT			2a. DATE OF DEATH MONTH DAY YEAR September 10, 1980			2b. HOUR P 11:10 M			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 6-20-1894		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS		7b. HOUR P 11:10 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10 CITY OR TOWN OF DEATH Balto.		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.				13b. COUNTY		13c. CITY OR TOWN Balto. Md.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Louis M. Schuerholz				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosie Vahle					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 212-05-9015		17 INFORMANT ADDRESS Mr. Kurt F. Alt -6204 Everall Avenue-21206			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1539 DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma of the Colon DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
--	--	---	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (this hospital) attended the deceased from August 1, 1980, to September 10, 1980, that (we) last saw the deceased alive on September 10, 1980, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) did view the body after death.			
22a. SIGNATURE Marcia Good M.D.		22b. DATE SIGNED 9/10/80	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Marcia Good M.D.		22d. ADDRESS 9000 Franklin Square Drive 21237	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-15-80		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24 FUNERAL DIRECTOR NAME ADDRESS John C. Miller Inc-6415 Belair Rd.-21206				25a. DATE REC'D. BY REGISTRAR SEP 15 1980		25b. REGISTRAR'S SIGNATURE Kristy McCreedy	





11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 846. 847

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |   |  |                                       |   |                                   |  |  |
|--|--|--|---|--|---|--|---------------------------------------|---|-----------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |   |  | 2a. DATE OF DEATH   |  |                                       |   |                                   | 2b. HOUR                                     |  |
| FIRST MIDDLE LAST  |  |  |   |  | MONTH DAY YEAR  |  |                                       |   |                                   | MONTHS DAYS HOURS MIN.                       |  |
| CHARLES ROBERT AMMONS  |  |  |   |  | SEPTEMBER 24, 1980  |  |                                       |   |                                   | 8:30 P.M.                                    |  |
| 3. SEX   |  | 4. RACE  |   | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |                                       | 7. IF UNDER 1 YEAR  |                                   | 7. IF UNDER 24 HRS                           |  |
| MALE   |  | WHITE  |   | 11 MONTH 11 DAY 1933   |   | 46   |                                       | MONTHS DAYS   |                                   | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                       |   |                                   |  |  |
| MARYLAND   |  | U.S.A.   |   |  |   | BALTIMORE COUNTY MD.   |                                       |   |                                   |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |                                       |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| FORT HOWARD  |  | VAMC, FORT HOWARD, MARYLAND  |   |  |   | R.R. Worker  |                                       |   | P.&B.R.R.R.                       |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |  | 13b. INSIDE CITY LIMITS?  |  | 13c. STREET ADDRESS                   |   |                                   |  |  |
| 13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN Dundalk  |  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 7057 DUNBAR ROAD                      |   |                                   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                          |  |                                       |   |                                   |  |  |
| Albert B. Ammons   |  |  |   |  | Josephine M. Louden   |  |                                       |   |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS                 |   |                                   |  |  |
| YES  |  |  |   |  | POST KOREAN 212 30 3031   |  | Bernice L. Lewis Baltimore, Md. 21222 |   |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:  |  |  |   |  |   |  |                                       |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) PNEUMONIA  |  |  |   |  |   |  |                                       |   |                                   | UNKNOWN                                      |  |
| 1455 DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF THE PALATE  |  |  |   |  |   |  |                                       |   |                                   | UNKNOWN                                      |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |   |  |   |  |                                       |   |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |   |  |   |  |                                       |   |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |   |  |                                       |   |                                   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   | 20a. AUTOPSY?  |                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                                   |  |  |
|  |  |  |   |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                       | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                       |   |                                   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                       |   |                                   |  |  |
| 22a. I certify that (this hospital) attended the deceased from SEPTEMBER 9, 1980, to SEPTEMBER 24, 1980, that (we) last saw the deceased alive on SEPTEMBER 24, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |   |  |                                       |   |                                   |  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   |  | 22c. DATE SIGNED  |  |                                       |   |                                   |  |  |
| SRINIVASAM L. NARASIMHAN M.D.  |  |  |   |  | 9/25/1980   |  |                                       |   |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY    |   |                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE      |  |
| Cremation  |  |  |   |  | 9/26/80   |  | Green Mount Cem.                      |   |                                   | Baltimore, Maryland                          |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. SIGNATURE                        |   |                                   |  |  |
| Duda-Ruck Funeral Home of Dundalk, Inc.  |  |  |   |  | SEP 30 1980   |  |                                       |   |                                   |  |  |



NOTED 2/20/80

SEP 20 1980

*Handwritten signature*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  | 80 22047   |  |
|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  |   |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST<br><b>Robert</b>  |  | MIDDLE<br><b>L.</b>   |  | LAST<br><b>Anderson Sr.</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>September 20, 1980</b>   |  | 2b. HOUR<br><b>6 A M</b>   |  |
| 3 SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Jan. 12, 1920</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS.                                 |  | IF UNDER 1 YEAR MONTHS DAYS<br><b>60</b>  |  | IF UNDER 24 HRS. HOURS MIN.<br><b>60</b>   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.               |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph's Hospital</b>    |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Boiler Maker</b>                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>  |  |   |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Arthur E. Anderson</b>   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Alice T. Vaughan</b>             |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES)<br><b>Army WW II 220-07-2989</b>  |  | 17. INFORMANT <b>Wife:</b>  |  | ADDRESS <b>Balt., Md. 21212</b><br><b>Elnora F. Anderson 866 Benninghaus Road</b> |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.<br><b>410 -</b> |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>at least 34.</b>                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>1900 N. Northern Pkwy Baltimore, Md.</b>   |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 27 70</b> , to <b>Sep 6 80</b> , that (I) <del>was</del> last saw the deceased alive on <b>9-6-80</b> , 19 <b>80</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>will not</del> (did not) view the body after death.  |  |   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>CE Aranaga M.D.</b>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  |   |  | 22c. DATE SIGNED<br><b>9-22-80</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Carlos E. Aranaga M.D.</b>   |  | 22e. ADDRESS<br><b>1900 N. Northern Pkwy Baltimore, Md.</b>   |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Sep 23, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>              |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc.</b>   |  | NAME<br><b>Baltimore, Maryland</b>  |  | ADDRESS<br><b>Baltimore, Maryland</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 22 1980</b>                               |  | 25b. REGISTRAR'S SIGNATURE<br><b>R. J. Ruck</b>   |  |  |  |

Robert J. Anderson Jr. September 30, 1940

Male White 12. 12, 1920

Weymouth Baltimore County

Lowson St. Joseph's Hospital

Weymouth Baltimore X

Arthur Anderson Alice T. 1940

Yes 230-07-2359 T. Anderson 800

T. Carlos A. Anderson M.D. 1900 W. Northern Hwy. Baltimore, Md.

Levin 300 23, 1920 Parkwood Institute Baltimore Maryland

Leonard J. Cook, Inc. Baltimore, Maryland

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                                 |  |   |  |  |  |   |  |   |  | REG. NO. 80 22048  |  |   |  |
|--|--|---------------------------------|--|---|--|--|--|---|--|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR   |  |                                 |  |   |  |  |  |   |  |   |  | 2a DATE KNOWN OF DEATH   |  | 2b HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>LILLIE MAE ARMIGER</b>  |  |                                 |  |   |  |  |  |   |  |   |  | ESTIMATED <input checked="" type="checkbox"/> 09 01 19 80                |  | 9 25 M  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>         |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 13 97</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82 YRS.</b>  |  | IF UNDER 1 YR. MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.   |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>9-2 19 80</b>           |  | 2d HOUR<br><b>2 25 P M</b>                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  |                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.      |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>ARBUTUS</b>  |  |                                 |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4757 ALDGATE GREEN, 21227</b> |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b> |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b> |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                                 |  |   |  |  |  |   |  |   |  |  |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b> |  | 13c. CITY OR TOWN<br><b>ARBUTUS</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>4757 ALDGATE GREEN, 21227</b>   |  |   |  |  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>BENJAMIN FRANKLIN ARMIGER II</b>   |  |                                 |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ELIZABETH TIPPETT</b>                       |  |   |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>NO</b>  |  |                                 |  | 16b. SOCIAL SECURITY NO.<br><b>214-14-5592</b>  |  | 17. INFORMANT ADDRESS<br><b>J. GORDON FLAUTT 1236 CIRCLE DRIVE</b>                           |  |   |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                    |  |                                 |  |   |  |  |  |   |  |   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                                 |  |   |  |  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                                 |  |   |  |  |  |   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Conrado Ferrero</b>  |  |                                 |  | TITLE (SPECIFY) <b>Deputy</b>   |  |  |  | MEDICAL EXAMINER  |  |   |  | DATE SIGNED <b>9-2-80</b>  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>CONRADO FERRERO</b>   |  |                                 |  | ADDRESS <b>5550 Baltimore Ave. P.O.</b>   |  |  |  |   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |                                 |  | 23b. DATE<br><b>09-04-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FRIENDSHIP METH. CH.</b>                            |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>FRIENDSHIP A.A. MD.</b>          |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>   |  |                                 |  | ADDRESS<br><b>4107 WILKENS AVE.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 3 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert A. Brady</i>                              |  |  |  |   |  |

Autosport (Continued)

Autosport (Continued)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

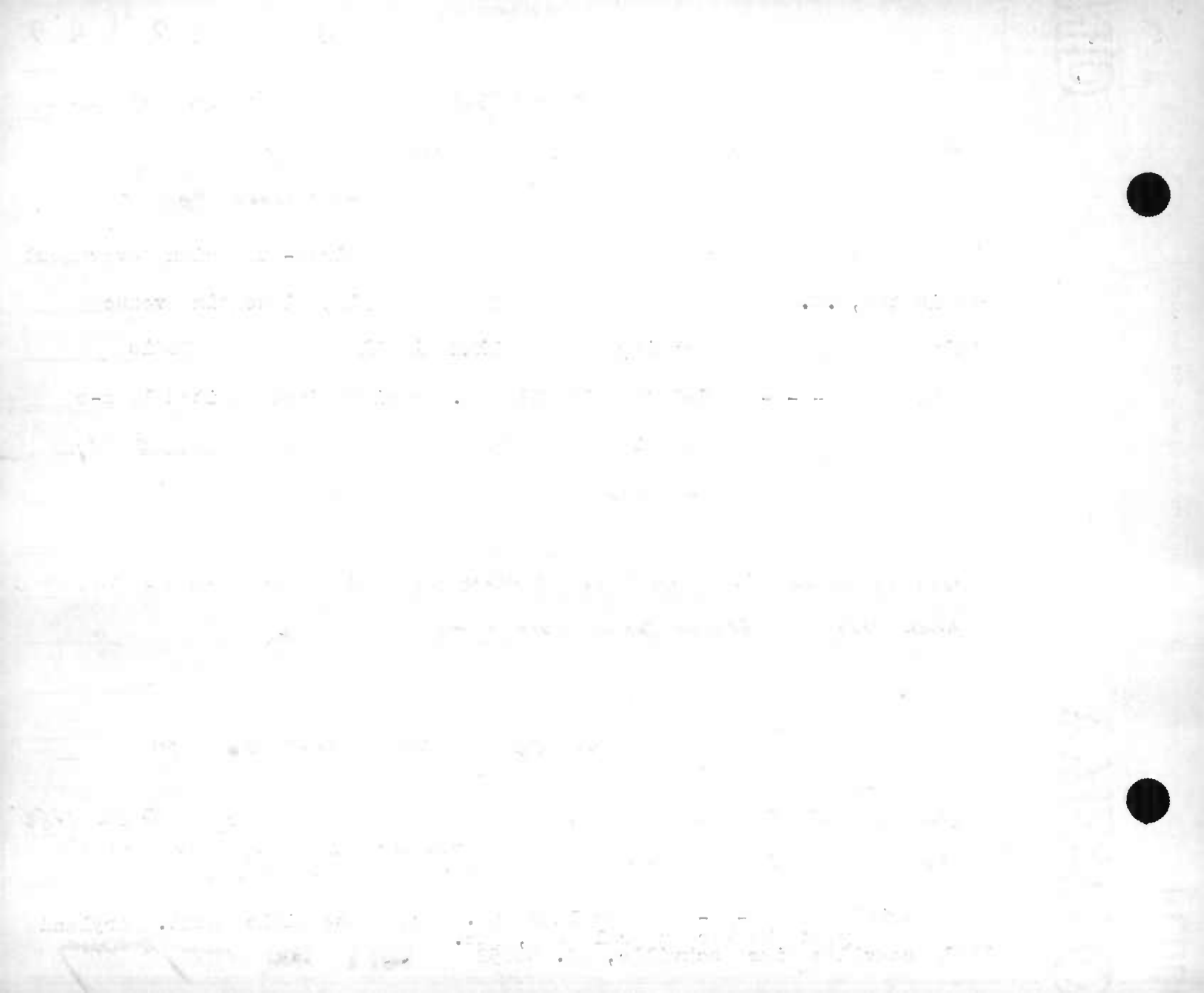
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "g" item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | 80 22049   |  |              |  |         |  |
|--|--|---|--|---|--|--|--|--|--|--|--|--------------|--|---------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 7a. DATE OF DEATH   |  |   |  |  |  | 7b. HOUR   |  |  |  |              |  |         |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>LAJOS  |  | MIDDLE  |  | LAST<br>BABNIGG  |  | MONTH<br>9   |  | DAY<br>26  |  | YEAR<br>1980 |  | 530 P M |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH<br>6 DAY<br>26 YEAR<br>1903   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS  |  | IF UNDER 24 HRS<br>HOURS<br>MIN.                       |  |              |  |         |  |
| 7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>HUNGARY   |  | 7d. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                         |  |  |  |  |  |              |  |         |  |
| 10. CITY OR TOWN OF DEATH<br>CATONSVILLE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SPRING GROVE HOSPITAL CENTER |  |   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired-Hungarian Government                           |  | 12b. KIND OF BUSINESS OR INDUSTRY                      |  |              |  |         |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Washington, D.C.   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>3130 Wisconsin Avenue   |  |  |  |  |  |              |  |         |  |
| 14. FATHER'S NAME<br>FIRST<br>Bela   |  | MIDDLE  |  | LAST<br>Babnigg   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Irene   |  | MIDDLE<br>Gizell   |  | LAST<br>Bodis  |  |              |  |         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>--- --  |  | 17. INFORMANT<br>141 32 8020  |  | ADDRESS<br>Ilma A. Babnigg Same as item 13 a-e                                       |  |  |  |  |  |              |  |         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE<br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) ASCVD<br>(c) DUE TO, OR AS A CONSEQUENCE OF          |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 days |  |              |  |         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>RETROCARDIAL MASS (METASTATIC?) SEC. 8 ADENOCARCINOMA OF THE PROSTATE STAGE CORD  |  |   |  |   |  |  |  |  |  |  |  |              |  |         |  |
| 19a. DATE OF OPERATION<br>MARCH 1977   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>BENIGN PROSTATE HYPERTROPHY   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |              |  |         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |  |              |  |         |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN   |  | COUNTY   |  | STATE  |  |              |  |         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 26 19 67 to SEPT. 26 19 80, that (I) (we) lost<br>saw the deceased alive on SEPT. 26 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |  |  |              |  |         |  |
| 22b. SIGNATURE<br>Benjamin B. Bandong  |  | DEGREE<br>M.D.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |  |  | 22c. DATE SIGNED<br>9-26-1980  |  |  |  |              |  |         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BENJAMIN B. BANDONG   |  | 22e. ADDRESS<br>SPRING GROVE HOSPITAL CENTER<br>CATONSVILLE MD. 21228   |  |   |  |  |  |  |  |  |  |              |  |         |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>9-30-80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parklawn Mem. Park  |  | 23d. LOCATION<br>CITY OR TOWN<br>Rockville   |  | COUNTY<br>Mont.  |  | STATE<br>Maryland                                      |  |              |  |         |  |
| 24. FUNERAL DIRECTOR<br>Tyson Wheeler Funeral Home, Inc.<br>1331 Rockville Pike Rockville, Md. 20852   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 1 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |  |  |              |  |         |  |

BP \_\_\_\_\_



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 0 5 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

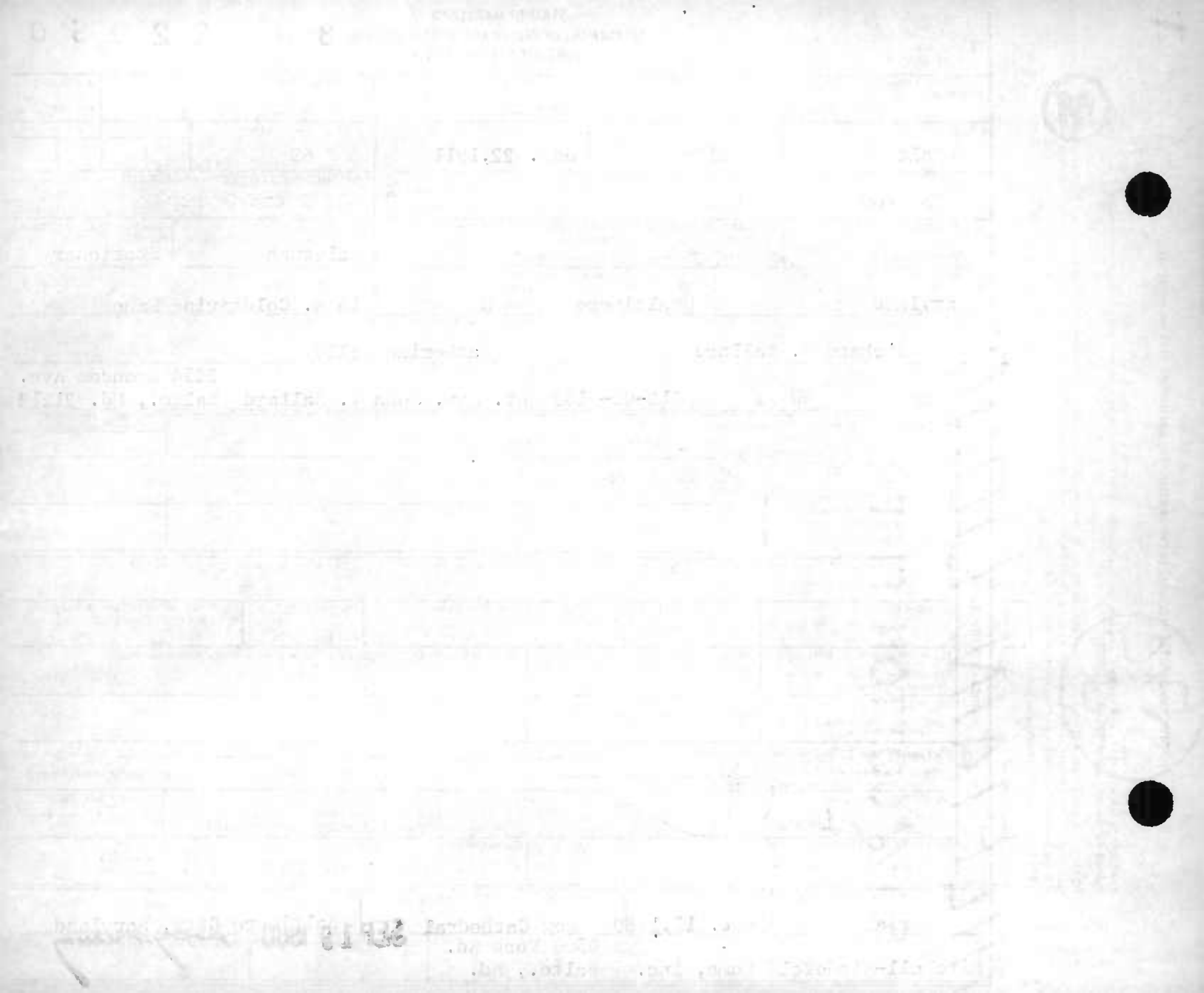
|  |   |  |   |  |  |
|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Harold J. Ballard</b>   |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 14, 1980</b>                        |  | 2b. HOUR<br><b>8:55p M</b>   |
| 3 SEX<br><b>Male</b>   | 4 RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 22, 1911</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b><br>YRS MONTHS DAYS HOURS MIN.                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b><br>MD.                              |  |
| 10 CITY OR TOWN OF DEATH<br><b>Towson</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Stationary</b>   |
| 13a. STATE<br><b>Maryland</b>  |   |  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Richard W. Ballard</b>   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Katherine Kelly</b>             |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WW II</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>212-03-9182</b>   |   | 17 INFORMANT<br>ADDRESS<br><b>2854 Brendan Ave.<br/>Rt. Rev. John V. Ballard Balto., Md. 21213</b> |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c):<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Massive Pulmonary embolism</b><br>4151<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(ATHOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Aug. 29, 1980</b> to <b>Sept. 14, 1980</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>Sept. 14, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (we did) (we did not) view the body after death. |   |  |   |  |  |
| 22b. SIGNATURE<br><i>Samuel Lee</i>  |   | DEGREE   |   | 22c. DATE SIGNED<br><b>Sept. 15, 1980</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Samuel Lee, M.D.</b>   |   | 22e. ADDRESS<br><b>7620 York Road, Towson, Md. 21204</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>Sept. 17, 1980</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City, Maryland</b>  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Mitchell-Wiedefeld Home, Inc.</b>  |   | ADDRESS<br><b>6500 York Rd. Balto., Md.</b>  |   | 25a. REG. NO. BY REGISTRAR<br><b>SEP 18 1980</b>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |  |   |  |   |   |   | REG. NO. 80 22051                                   |  |
|---|--|---|---|--|---|--|---|---|---|---|--|
| 1. FOR STATE REGISTRAR  |  |   | 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Rosa M. Balsamo</i> |  |   |  | 2a DATE OF DEATH MONTH DAY YEAR<br><i>Sept. 7, 1980</i>                                     |   |   | 2b HOUR<br><i>6:54 AM</i>                           |  |
| 3 SEX<br><i>FEMALE</i>  |  | 4 RACE<br><i>White</i>  |   | 5 DATE OF BIRTH MONTH DAY YEAR<br><i>Nov. 5, 1903</i>  |   | 6 AGE (IN YEARS LAST BIRTHDAY) YRS<br><i>76</i>                                  |   | IF UNDER 1 YEAR MONTHS DAYS                                     |   | IF UNDER 24 HRS HOURS MIN.                          |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Md.</i>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.               |   |   |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><i>Randallstown</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Baltimore County General Hosp.</i> |   |  |   | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i> |   | 12b KIND OF BUSINESS OR INDUSTRY                                |   |   |  |
| 13a STATE<br><i>Md.</i>   |  |   | 13b COUNTY<br><i>Balto.</i>   |  | 13c CITY OR TOWN<br><i>Baltimore</i>  |  | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e STREET ADDRESS<br><i>9634 Alda Drive</i>  |   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><i>Frank Bianca</i>   |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Jacqueline Amoscato</i>   |   |  |   |   |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>no</i>   |  |   | 16b SOCIAL SECURITY NO.<br><i>219-12-6091</i>                               |  | 17 INFORMANT ADDRESS<br><i>Mrs. Jacqueline Brocius same</i>                   |  |   |   |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardio - Pulmonary arrest</i>  |  |   |   |  |   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |  |
| 4292 } DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congestive Heart Failure</i>   |  |   |   |  |   |  |   |   |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>A S C &amp; D</i>   |  |   |   |  |   |  |   |   |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>G.I. bleeding</i>   |  |   |   |  |   |  |   |   |   |   |  |
| 19a DATE OF OPERATION   |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>              |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |   |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  |   | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |   |   |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <i>Aug. 14, 1980</i> to <i>Sept. 7, 1980</i> , that (I) (we) lost <i>saw the deceased alive on Sept. 7, 1980</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |   |  |   |  |   |   |   |   |  |
| 22b SIGNATURE <i>G. H. S. Pournat</i>   |  |   |   | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>          |   |  |   | 22c. DATE SIGNED <i>9-7-80</i>                                  |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>G. H. S. Pournat</i>  |  |   |   | 22e ADDRESS<br><i>Balto. County Gen. Hospital</i>  |   |  |   |   |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  |   | 23b DATE<br><i>Sept. 10, 1980</i>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><i>New Cathedral</i>                     |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Baltimore Md.</i> |   |   |  |
| 24 FUNERAL DIRECTOR NAME<br><i>Leonard J. Ruck Inc.</i>   |  |   |   | ADDRESS<br><i>Baltimore, Maryland</i>  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>SEP 8 1980</i>              |   | 25b REGISTRAR'S SIGNATURE<br><i>Robert McCreedy</i> |  |



Items #1a-22a Film 5448 10/15/80 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

8 0 2 2 0 5 2

|  |         |  |        |   |                            |   |                  |   |                                |       |   |
|--|---------|--|--------|---|----------------------------|---|------------------|---|--------------------------------|-------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  | MIDDLE | LAST  | 2a. DATE KNOWN<br>OF DEATH |   | ESTI-<br>MATED   | MONTH   | DAY                            | YEAR  | 2b. HOUR  |
| Ernest Augusta Bartee  |         |  |        |   | 8 13 80                    |   |                  |   |                                |       | M   |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |        | 6. AGE (IN YEARS<br>LAST BIRTHDAY)  | IF UNDER 1 YR.             |   | IF UNDER 24 HRS. |   | 7c. DATE<br>PRONOUNCED<br>DEAD |       | 2d. HOUR  |
| male   | black   | 3 21 53  |        | 27 YRS.   | MONTHS DAYS HOURS MIN.     |   |                  |   | 8 16 80                        |       | 4:00 p.m.                                       |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                  |   |                                |       |   |
| Balto., Md.  |         | U.S.A.   |        |   |                            | Baltimore County MD   |                  |   |                                |       |   |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |   |                            | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |                  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |                                |       |   |
| Watersedge Park  |         | Watersedge Park  |        |   |                            | Bethlehem Steel   |                  | Steel   |                                |       |   |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |         |  |        |   |                            |   |                  |   |                                |       |   |
| 13a. STATE   |         | 13b. COUNTY  |        | 13c. CITY OR TOWN   |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |                  | 13e. STREET ADDRESS   |                                |       |   |
| Md.  |         |  |        | Balto.  |                            |   |                  | 1404 Northgate Rd.  |                                |       |   |
| 14. FATHER'S NAME  |         |  |        | 15. MOTHER'S MAIDEN NAME  |                            |   |                  |   |                                |       |   |
| FIRST MIDDLE LAST  |         |  |        | FIRST MIDDLE LAST   |                            |   |                  |   |                                |       |   |
| Eddie Bartee   |         |  |        | Christine Lemon   |                            |   |                  |   |                                |       |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |         |  |        | 16b. SOCIAL SECURITY NO.  |                            | 17. INFORMANT ADDRESS   |                  |   |                                |       |   |
| no   |         |  |        | 215 60 2893   |                            | Mr. Eddie Bartee 1404 Northgate Rd.   |                  |   |                                |       |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Undetermined</u><br>7999<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |         |  |        |   |                            |   |                  |   |                                |       | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |         |  |        |   |                            |   |                  |   |                                |       |   |
| 19a. DATE OF OPERATION   |         |  |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                            |   |                  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                |       |   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |  |        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>Unknown 8/14/80  |                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Unknown                                      |                  |   |                                |       |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |         |  |        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, UNKNOWN)<br>Unknown   |                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Between Peninsula Expy. & Watersedge Pk<br>Bear Creek Baltimore Co., Md. |                  |   |                                |       |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquest <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . |         |  |        |   |                            |   |                  |   |                                |       |   |
| ACTUAL SIGNATURE   |         |  |        | TITLE (SPECIFY)   |                            |   |                  | DATE SIGNED   |                                |       |   |
| H.R.S. Ward  |         |  |        | M.D. Assistant MEDICAL EXAMINER   |                            |   |                  | 8/17/80   |                                |       |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         |  |        | ADDRESS   |                            |   |                  |   |                                |       |   |
| Hormez R. Guard, M.D.  |         |  |        | 111 Penn Street, Balto., MD 21201   |                            |   |                  |   |                                |       |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY  |                            | 23d. LOCATION<br>CITY OR TOWN   |                  | COUNTY  |                                | STATE |   |
| Burial   |         | 9/12/80  |        | Cedar Hill  |                            | Brooklyn,   |                  | Md.   |                                |       |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |         |  |        |   |                            | 25a. DATE REC'D. BY REGISTRAR   |                  | 25b. REGISTRAR'S SIGNATURE  |                                |       |   |
| Jas. A. Morton & Sons 1701 Laurens Street  |         |  |        |   |                            | SEP 15 1980   |                  | R. J. McCreary  |                                |       |   |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IT SHOULD BE EXECUTED WITHIN 72 HOURS. THE MEDICAL EXAMINER SHOULD SIGN AND DATE THIS CERTIFICATE. IF THE MEDICAL EXAMINER IS NOT AVAILABLE, THE CERTIFICATE SHOULD BE SIGNED BY A DEPUTY MEDICAL EXAMINER. IF THE MEDICAL EXAMINER IS NOT AVAILABLE, THE CERTIFICATE SHOULD BE SIGNED BY A DEPUTY MEDICAL EXAMINER. IF THE MEDICAL EXAMINER IS NOT AVAILABLE, THE CERTIFICATE SHOULD BE SIGNED BY A DEPUTY MEDICAL EXAMINER.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ENCOUNTERED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                                 |  |  |  |  |  |   |  | REG. NO. 8 0 2 2 0 5 3   |  |
|--|--|---------------------------------|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ETHEL U. BARTLEY</b>  |  |                                 |  |  |  | 2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>9 4 80</b>   |  | 2b. HOUR<br><b>8:09</b> M   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>         |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>4 15 94</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>86 YRS.</b>   |  | 7c. DATE PRONOUNCED DEAD<br><b>9 4 80</b>   |  | 7b. HOUR<br><b>8:09</b> M  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  |                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balti Co.</b> MD.                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Gonville Md</b>  |  |                                 |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Francis &amp; Hoop 21237</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>----</b>                                 |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                                 |  |  |  |  |  |   |  |  |  |
| 13a. STATE<br><b>Md</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b> |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>6228 Radecke 21206</b>                                  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>----- LILLY</b>  |  |                                 |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>-----</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>NO</b>  |  |                                 |  | 16b. SOCIAL SECURITY NO.<br><b>213484600</b>   |  | 17. INFORMANT ADDRESS<br><b>JOHN ROTH 9243 HARFORDVIEW DR.</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4292 Atherosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>unc</b>        |  |                                 |  |  |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                                 |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                                 |  |  |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>John C. Hyle</b>  |  |                                 |  | TITLE (SPECIFY)<br><b>Dph</b>  |  |  |  | DATE SIGNED<br><b>9-4-80</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>JOHN C. Hyle</b>   |  |                                 |  | ADDRESS<br><b>7527 Belair Rd Balt 21236 Md.</b>  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |                                 |  | 23b. DATE<br><b>9/8/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>IVY HILL CEMETERY</b>   |  | 23d. LOCATION CITY OR TOWN<br><b>LAUREL</b>                                       |  | STATE<br><b>MD.</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>John Cook</b>  |  |                                 |  |  |  | ADDRESS<br><b>1211 Chesapeake Ave.</b>   |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>SEP 11 1980</b>                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>notary/John Cook</b>                            |  |



11/11/44

20% COTTON



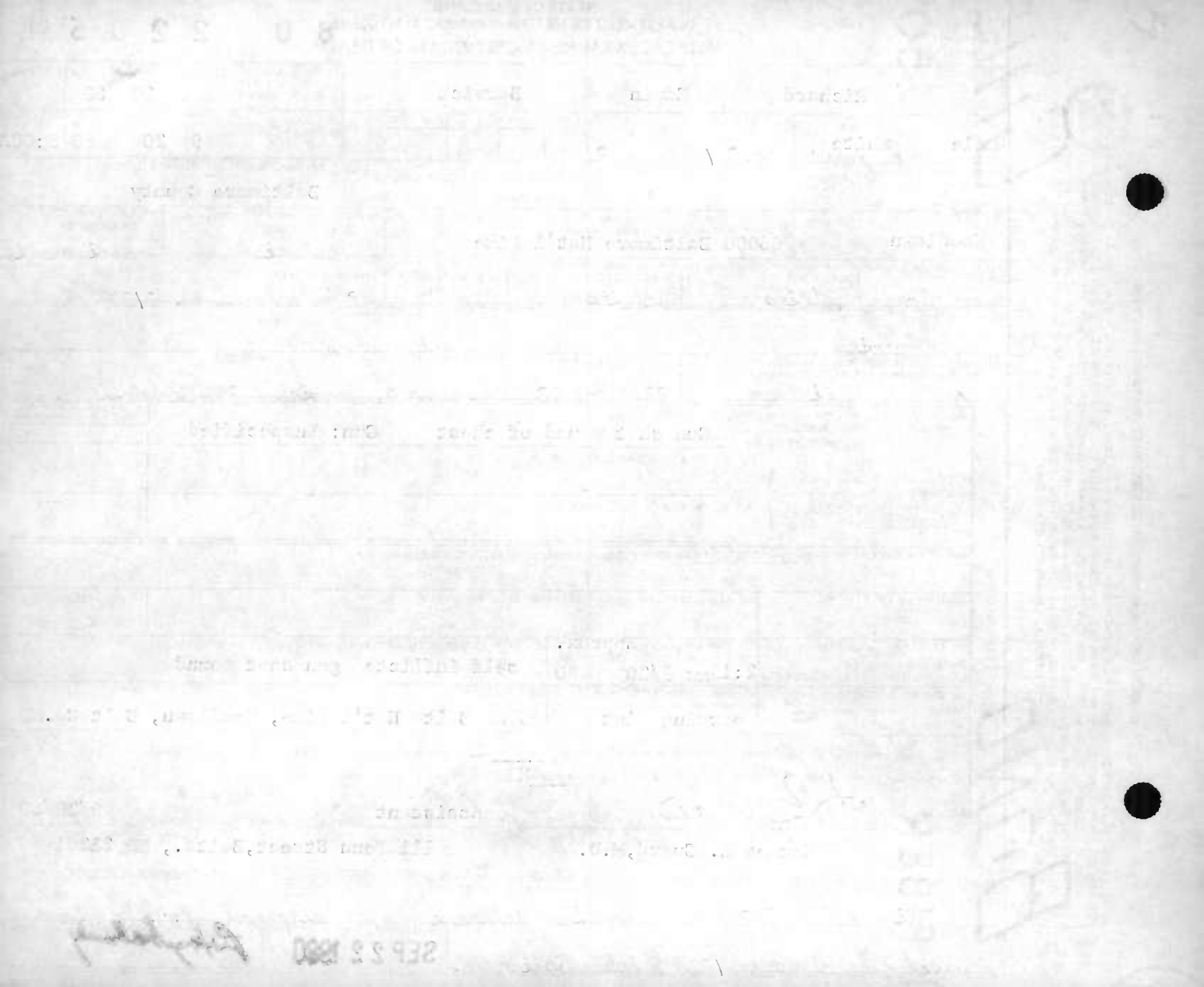
NOV 11 1944

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

8 0 2 2 0 5 4

|  |                         |   |   |  |   |   |   |  |
|--|-------------------------|---|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Richard Edwin Barwick</b>  |                         |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>9 20 1980</b>                                     |  |   | 2b. HOUR<br>M<br><b>5:00A</b>   |   |  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 3, 1949</b> | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>30</b> YRS.  | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>30</b> | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>30</b> | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>9 20 1980</b>  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         |   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Woodlawn</b>   |                         |   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>66000 Baltimore Nat'l Pike</b> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |                         |   | 13b. COUNTY<br><b>Baltimore</b>   |  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Barwick</b>   |                         |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dolly Thomas</b>  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mechanic</b>  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>yes</b>  |                         |   | 16b. SOCIAL SECURITY NO.<br><b>220-52-2822</b>  |  |   | 17. INFORMANT<br><b>Roxanne B. Barwick</b>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gun shot wound of chest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br><b>9554</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |   | Gun: Unspecified  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |   |   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>Approx. 2:15xx 9/20 1980</b>  |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>self inflicted gun shot wound</b>                                       |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>parking lot</b>   |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>66000 Balto Nat'l Pike, Woodlawn, BaltoCo.MD</b>  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |   |   |  |   |   |   |  |
| ACTUAL SIGNATURE<br><b>H. R. Guard</b>   |                         |   | TITLE (SPECIFY)<br><b>Assistant</b>   |  |   | DATE SIGNED<br><b>9/20/80</b>   |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>   |                         |   | ADDRESS<br><b>111 Penn Street, Balto., MD 21201</b>   |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         |   | 23b. DATE<br><b>9/24/80</b>   |  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Maryland Veterans</b>  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ambrose Funeral Home</b>  |                         |   | ADDRESS<br><b>1328 Sulphur Spring Rd.</b>   |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cheltenham P. Co. Maryland</b>   |   |  |
| 25a. DATE REC'D. BY REGISTRAR  |                         |   | 25b. REGISTRAR<br><b>P. J. H. H. H.</b>   |  |   | SEP 22 1980   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 0 5 5

REG. NO.

|   |  |   |  |   |   |  |  |  |   |                                  |  |  |  |  |
|---|--|---|--|---|---|--|--|--|---|----------------------------------|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ANITA CHRISTINA BAUER  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>September 23, 1980              |   |   | 2b. HOUR<br>11:30am  |  |  |   |                                  |  |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5-27-1901   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                        |   | 8. IF UNDER 24 HRS<br>HOURS MIN. |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virgin Islands   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |  |   |                                  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Home Maker   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                                  |  |  |  |  |
| 13a. STATE<br>Md.   |  |   | 13b. COUNTY<br>Balto.  |   |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 13d. STREET ADDRESS<br>1826 Eastern Avenue 21231  |                                  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Hans Madsen   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Laura                 |   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                      |  |  |   |                                  |  |  |  |  |
| 16a. SOCIAL SECURITY NO<br>217-01-1069 D  |  |   | 17. INFORMANT<br>Mrs. Marie LePore - 6500 Eastern Pkwy. 21206          |   |   |  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Acute Pulmonary Edema; Acute Left Ventricular Failure<br>4381<br>DUE TO, OR AS A CONSEQUENCE OF<br>Failure<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |   |  |  |  |   |                                  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |   |                                  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |                                  |  |  |  |  |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 15, 1980, to September 23, 1980, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on September 23, 1980, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death. |  |   |  |   |   |  |  |  |   |                                  |  |  |  |  |
| 22b. SIGNATURE<br>K. L. Rothbaum MD.  |  |   | DEGREE   |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br>9-23-80   |                                  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>K. L. Rothbaum   |  |   | 22e. ADDRESS<br>9000 Franklin Square Drive 21237                       |   |   |  |  |  |   |                                  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>9-26-80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Scared Heart of Jesus |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md. |   |                                  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>John C. Miller Inc-6415 Belair Rd.-21206  |  |   | ADDRESS  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>SEP 24 1980   |  |  | 25b. REGISTRAR'S SIGNATURE<br>Fistay Kibundu  |                                  |  |  |  |  |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE JUDICIAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN TO THE JUDICIAL DIRECTOR WITHIN 72 HOURS TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED TO THE JUDICIAL DIRECTOR WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
15M7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 80 22056

|  |        |  |                  |   |   |   |                         |  |        |              |         |
|--|--------|--|------------------|---|---|---|-------------------------|--|--------|--------------|---------|
| 1- FOR STATE REGISTRAR   |        | 2a. DECEASED NAME (TYPE OR PRINT)  |                  | FIRST MIDDLE LAST   |   | 2b. DATE KNOWN OF DEATH ESTI-MATED                                  |                         | MONTH DAY YEAR                               |        | 2c. HOUR     |         |
|  |        | SARA VERA BERANGER   |                  |   |   | 9/9   |                         | 1980   |        | A M          |         |
| 3 SEX  | 4 RACE | 5 DATE OF BIRTH  | 6 AGE (IN YEARS) | 7a. CITIZEN OF WHAT COUNTRY?  | 8 MARRIED                                   | 9 NEVER MARRIED   | 10 DATE PRONOUNCED DEAD | 11 MONTH                                     | 12 DAY | 13 YEAR      | 14 HOUR |
| FEMALE   | CAUCA. | 06 29 23   | 57 YRS.          | USA   | <input checked="" type="checkbox"/> MARRIED | <input type="checkbox"/> NEVER MARRIED                              | 9/9                     | 1980   |        |              | P M     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |        | 7b. CITIZEN OF WHAT COUNTRY?   |                  | 8 MARRIED   |   | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |                         |  |        |              |         |
| VIRGINIA   |        | USA  |                  | <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED            |   | BALTIMORE COUNTY  |                         |  |        | MD           |         |
| 10 CITY OR TOWN OF DEATH   |        | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                         |  |        |              |         |
| WHITE MARSH  |        | 44 ROSEWOOD MOBILE CT.   |                  | SEAMSTRESS  |   | CLOTHING  |                         |  |        |              |         |
| 13a. STATE   |        | 13b. COUNTY  |                  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?  |                         | 13e. STREET ADDRESS                          |        |              |         |
| MARYLAND   |        | BALTIMORE  |                  | WHITE MARSH   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                         | 44 ROSEWOOD MOBILE CT.                       |        |              |         |
| 14. FATHER'S NAME  |        | 15. MOTHER'S MAIDEN NAME   |                  |   |   |   |                         |  |        |              |         |
| THOMAS   |        | E. LUKHARD   |                  | PEARL   |   | HARRIS  |                         |  |        |              |         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |        | 16b. SOCIAL SECURITY NO.   |                  | 17. INFORMANT   |   | ADDRESS   |                         |  |        |              |         |
| NO   |        | 215245812  |                  | ALFRED BERANGER   |   | 44 ROSEWOOD MOBILE  |                         |  |        |              |         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).)   |        | PART I DEATH WAS CAUSED BY:  |                  | IMMEDIATE CAUSE (a)   |   | DUE TO, OR AS A CONSEQUENCE OF                                      |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |        |              |         |
| 410 -  |        | Acute Myocardial Infarction  |                  |   |   |   |                         |  |        |              |         |
|  |        | Chronic Cardiovascular   |                  |   |   |   |                         |  |        |              |         |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |        | 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                             |   | 20. AUTOPSY?  |                         |  |        |              |         |
| 1. Rheumatoid arthritis  |        |  |                  |   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                         |  |        |              |         |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |        | 21b. TIME OF INJURY  |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |   |   |                         |  |        |              |         |
|  |        | HOUR A.M. MONTH DAY YEAR   |                  |   |   |   |                         |  |        |              |         |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                  | 21f. LOCATION   |   | CITY OR TOWN  |                         | COUNTY                                       |        | STATE        |         |
|  |        |  |                  |   |   |   |                         |  |        |              |         |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: |        | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  | TITLE (SPECIFY)   |   | DATE SIGNED   |                         |  |        |              |         |
| ACTUAL SIGNATURE   |        | K. S. AHLUWALIA  |                  | M.D. Deputy   |   | MEDICAL EXAMINER  |                         |  |        |              |         |
| EXAMINER'S NAME (TYPE OR PRINT)  |        | K. S. AHLUWALIA  |                  | ADDRESS   |   | 2112 Dundack Ave  |                         | Baltimore                                    |        | MD           |         |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |        | 23b. DATE  |                  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION   |                         | CITY OR TOWN                                 |        | COUNTY STATE |         |
| CREMATION  |        | 9/11/80  |                  | WESTVIEW MEM. PARK  |   | BALTO   |                         |  |        |              |         |
| 24. FUNERAL DIRECTOR   |        | NAME   |                  | ADDRESS   |   | 25a. DATE REC'D. BY REGISTRAR                                       |                         | 25b. REGISTRAR'S SIGNATURE                   |        |              |         |
|  |        | John Gash  |                  | 1211 Chesaca Ave.   |   | SEP 15 1980   |                         | R. J. McCreedy                               |        |              |         |

|                             |  |                               |  |
|-----------------------------|--|-------------------------------|--|
| TO: <i>Mr. [illegible]</i>  |  | FROM: <i>Mr. [illegible]</i>  |  |
| SUBJECT: <i>[illegible]</i> |  | REFERENCE: <i>[illegible]</i> |  |
| DATE: <i>[illegible]</i>    |  |                               |  |
| PLACE: <i>[illegible]</i>   |  |                               |  |
| REMARKS: <i>[illegible]</i> |  |                               |  |



|                              |  |                                     |  |
|------------------------------|--|-------------------------------------|--|
| APPROVED: <i>[illegible]</i> |  | DATE: <i>[illegible]</i>            |  |
| SPECIAL AGENT IN CHARGE      |  | OFFICE OF THE SECRETARY OF THE ARMY |  |
| WASHINGTON, D. C. 20315      |  | FORM NO. 10-61 (REV. 1-61)          |  |

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 2 0 5 7

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |  |  |   |                      |  |
|---|--|--|--|---|----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ROSE XXX BERMAN   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>SEPTEMBER 9, 1980 |   | 2b. HOUR P<br>5:25 M |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JULY 23, 1892   |                      |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PENNSYLVANIA   |  | 8. CITIZEN OF WHAT COUNTRY?<br>USA  |                      |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.  |  | 10. CITY OR TOWN OF DEATH<br>TOWSON  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. JOSEPH HOSPITAL                |                      |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME   |  | 13a. STREET ADDRESS<br>5508 PRICE AVE. #21215   |                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSEPH SOLOMON SUGAR  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>FANNIE REBECCA BLUM   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |                      |  |
| 16b. SOCIAL SECURITY NO.<br>217-48-3669   |  | 17. INFORMANT<br>MR. PHILIP BERMAN   |  | 3917 SYBIL RD., RANDALLSTOWN, MD 21133  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebrovascular ACCIDENT<br>486-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) PNEUMONIA<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. |  |  |  |   |                      |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                      |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                      |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                      |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 22a. I certify that (X) this hospital attended the deceased from SEPT. 7, 19 80, to SEPT 9, 19 80, that (X) (we) lost saw the deceased alive on SEPT 9, 19 80, and that in (my your) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death. |  |   |                      |  |
| 22b. SIGNATURE<br>Beatriz P. Dizon M.D.   |  | DEGREE<br>M.D.   |  | 22c. DATE SIGNED<br>Sept. 9, 1980   |                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BEATRIZ P. DIZON, M.D.   |  | 22e. ADDRESS<br>7620 YORK RD. 21204  |  | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>SEPT. 14, 1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ADATH YESHURON  |                      |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND  |  | 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD., BALTO., MD 21215   |  |   |                      |  |
| 25a. DATE REC'D. BY REGISTRAR<br>SEP 19 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |   |                      |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 0 5 8

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |        |  |   |   |  |   |
|---|--|--|--------|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>Marion  | MIDDLE | LAST<br>Berry  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Sept. 9, 1980                                  |   | 2b. HOUR<br>2 P.M.   |   |
| 3 SEX<br>Female   |  | 4 RACE<br>White  |        | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>July 8, 1895  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>85                        |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N. J.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |        | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore Co. MD.    |  |   |
| 10 CITY OR TOWN OF DEATH<br>Reisterstown  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT SUCH FACILITY, GIVE STREET ADDRESS)<br>12923 Dover Road |        |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Secretary |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE<br>Md.   |  |  |        | 13b. COUNTY<br>Balto.  |   | 13c. CITY OR TOWN<br>Reisterstown                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Komer VanKirk  |  |  |        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Feeley   |   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>138-30-4565   |        | 17. INFORMANT<br>ADDRESS<br>Mrs. Sarah Liebendorfer Reisterstown, Md.  |   |   |  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARCINOMA OF COLON</u><br>1539<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |        |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 MO.  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |        |  |   |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |        |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> 19 <u>80</u> , to <u>SEPT 9</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>SEPT 2</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |        |  |   |   |  |   |
| 22b. SIGNATURE<br><u>A. Kleeman</u> M.D.  |  |  |        | DEGREE<br>M.D.   |   | 22c. DATE SIGNED<br>9.10.80                                 |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>J. KLEEMAN</u>  |  |  |        | 22e. ADDRESS<br>7600 OSLER DRIVE TOWSON 21204  |   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Sept. 13, 80  |        | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Lawn Cemetery  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Clifton N. J. |  |   |
| 24 FUNERAL DIRECTOR<br>NAME<br>Eline Funeral Home Reisterstown, Md. 21136   |  |  |        | 25a. DATE REC'D. BY REGISTRAR<br>SEP 11 1980   |   | 25b. REGISTRAR'S SIGNATURE<br><u>R. Kelly</u>               |  |   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

*[Faint, illegible text at the bottom of the page]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

DD FORM 16-30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |   |  |  |                                      | 8022059  |  |  |  |
|--|--|---|--|---|---|---|--|--|--------------------------------------|--|--|--|--|
| FOR STATE REGISTRAR  |  |   |  |   |   |   |  |  |                                      | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>ARTHUR AUGUST BESOLD</b>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>9/27/80</b>                |   |  |  | 2b. HOUR<br><b>1:15P<sub>M</sub></b> |  |  |  |  |
| SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>June 17, 1908</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS  |                                      | IF UNDER 24 HRS. HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                              |  |  |                                      |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS)<br><b>GBMC--6701 N. CHARLES ST.</b> |  |   |   |   |  | 12a. USUAL OCCUPATION (TYPE OR GIVE FULL OF WORKING LIFE)<br><b>Floor covering craftsman</b>   |                                      | 12b. KIND OF BUSINESS OR<br><b>NA</b>  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |   |   |  |  |                                      |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Overlea</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>7207 Belair Rd</b>   |                                      |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>William Henry Besold</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Laura Harker</b> |   |  |  |                                      |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>215-05-1565</b>  |   | 17 INFORMANT ADDRESS<br><b>Mrs Evelyn M Besold Same</b>   |  |  |                                      |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>PULMONARY-CARDIAC FAILURE</b><br><b>1419</b><br>IMMEDIATE CAUSE (a) } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CA OF TONGUE AND LUNG</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) }<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 DAY</b><br><b>1 YEAR</b> |  |   |  |   |   |   |  |  |                                      | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>9/26/80</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |                                      |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>80 9/27/80</b>                             |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>9/27/80</b> to <b>9/27/80</b> , that (I) (we) last saw the deceased alive on <b>9/27/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                                      |  |  |  |  |
| 22b. SIGNATURE<br><b>Hu Chen Lien M.D.</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |   |   |  | 22c. DATE SIGNED<br><b>9/27/80</b>   |                                      | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HU CHEN-LIEN</b>   |  |  |  |
| 22e. ADDRESS<br><b>GBMC--6701 N. CHARLES, STREET</b>   |  |   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   |   |  |  |                                      |  |  |  |  |
| 23b. DATE<br><b>9/30/80</b>  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>   |   |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |                                      |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>  |  |   |  |   |   | 25a. DATE REC'D BY REGISTRAR<br><b>SEP 30 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |                                      |  |  |  |  |



UNITED STATES

DEPARTMENT OF COMMERCE

WASHINGTON

1917

COMMISSIONER OF CUSTOMS

1917

OFFICE OF THE COMMISSIONER

1917

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RECEIVED

SEP 30 1900



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 2 0 6 0

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>FRIEDA M. BIGGS</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09 26 80</b>                 |   |  | 2b. HOUR<br><b>4 P. M.</b>  |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07 25 05</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YEARS MONTHS DAYS<br><b>75</b>   |  | 7. IF UNDER 1 YEAR<br>IF UNDER 24 HRS.<br>HOURS MIN.<br><b>---</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>LANSLOWNE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>24 LAVERNE AVENUE, 21227</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |   |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>LANSLOWNE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>24 LAVERNE AVENUE, 21227</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN BURDETTE</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ARABELLA DEAN</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>213-62-3169</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>JOSEPH L. BIGGS 24 LAVERNE AVENUE</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arterial Fibrillation</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypertensive Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Diabetes Mellitus</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 years</u><br><u>15 years</u>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 6</u> 19 <u>79</u> to <u>Sept 26</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>9/14/80</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <u>view the body after death</u> .   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>John P. Urlock Jr.</u> M.D.<br>22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN P. URLOCK, JR., M.D.</b>  |  |  |  |   |  | DEGREE<br><b>M.D.</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED.<br><b>9/27/80</b>  |  |
| 23a. ADDRESS<br><b>1227 WASHINGTON BOULEVARD</b>   |  |  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>09-29-80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>  |  |  | ADDRESS<br><b>4107 WILKENS AVE.</b>                                    |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 29 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony M. Brady</u>  |  |

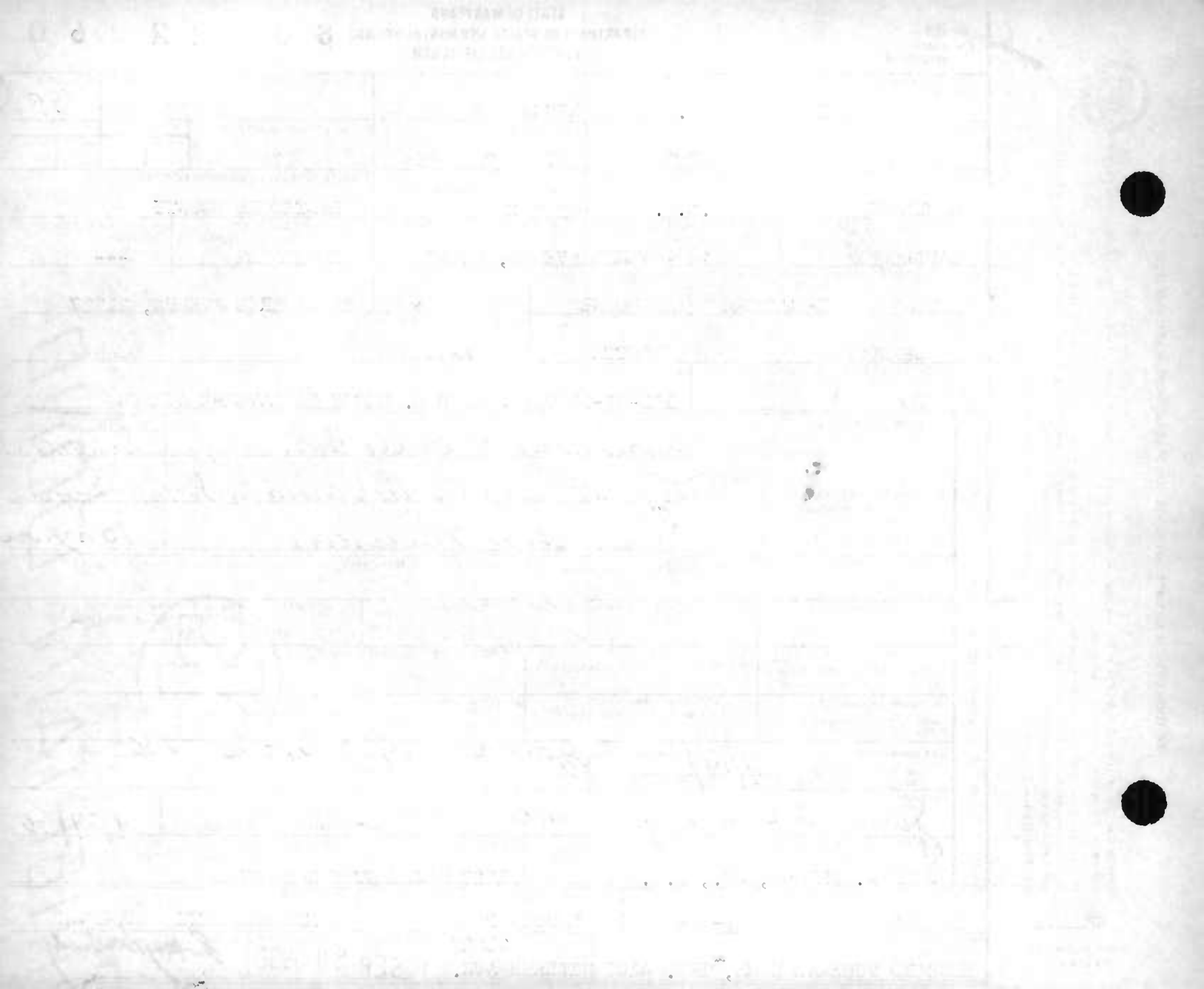
Examine must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 0 6 1

REG. NO.

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Helen Larue Billingsley |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>September 22, 1980                                       |   | 2b. HOUR<br>M  |
| 3. SEX<br>Female  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 19 1903   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.                | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                               | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |   |  |
| 10. CITY OR TOWN OF DEATH<br>Cockeysville   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>117 Glenmoore Ave. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>---                         |
| 13a. STATE<br>Md.   |   |   | 13b. COUNTY<br>Balto.   |   |  |
| 13c. CITY OR TOWN<br>Cockeysville   |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 13e. STREET ADDRESS<br>117 Glenmoore Ave., Cockeysville                             |   |   |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jarrett Eugene Thompson                   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Savinia Kemp                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No          |   | 16b. SOCIAL SECURITY NO.<br>218-74-1648   |   | 17. INFORMANT<br>Thomas R. Billingsley, 117 Glenmoore Ave |  |

|  |  |  |   |
|--|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Recurrent urinary tract infection</u><br>5990<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>diabetes mellitus</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>renal failure</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 year</u> |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>senility, seizure disorder, diabetes mellitus</u>   |  |  |   |
| 19a. DATE OF OPERATION<br><u>Sept 12</u>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>renal failure</u> | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>March 15</u> , 19 <u>80</u> , to <u>SEPT 22</u> , 19 <u>80</u> , that (1) (we) last saw the deceased alive on <u>Sept 12</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.       |  |  |   |
| 22b. SIGNATURE<br><u>Mark S. Kaplan</u>  | DEGREE   | 22c. DATE SIGNED<br><u>9/26/80</u>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Mark S. Kaplan, M. D.   | 22e. ADDRESS<br>16918 York Road, Monkton, Md.                            |  |   |

|  |                      |   |  |
|--|----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                 | 23b. DATE<br>9/24/80 | 23c. NAME OF CEMETERY OR CREMATORY<br>Bosley Meth. Ch. Cem. | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Sparks, Maryland |
| 24. FUNERAL DIRECTOR<br>NAME<br>J. E. Lowell Lemmon, 10 W. Padonia Rd. |                      | 25a. DATE REC'D. BY REGISTRAR<br>SEP 29 1980                | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>               |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 0 2 2 0 6 2   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GILBERT H. BITZ</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>Sept 19, 1980</b>  |  |   |  |
| 3 SEX<br><b>M</b>   |  | 4 RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>11 9 19</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Maintenance Maryland Cup Corpt.</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>PIKESVILLE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Franklin William Bitz</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Catherine Rutger</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>W.W. 2</b>  |  | 17. INFORMANT<br>ADDRESS <b>4111 Colonial Road Pikesville, MD 21208</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b><br><b>410 -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>OLD Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASCVD - Coronary Thrombosis</b> |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Small HRS</b><br><b>Small one year</b><br><b>years</b>   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c).  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22. I certify that (it) (this hospital) attended the deceased from <b>October 19, 69</b> to <b>Sept 19, 1980</b> , that (I) (we) <b>last</b> saw the deceased alive on <b>9/19/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (it) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |
| 23a. SIGNATURE<br><b>Herman Brecher M.D.</b>  |  |   |  | DEGREE<br><b>M.D.</b>   |  | 23c. DATE SIGNED<br><b>9/19/80</b>  |  |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HERMAN BRECHER, MD</b>  |  |   |  | 23d. ADDRESS<br><b>6410 WINDSOR MILL RD.</b>  |  |   |  |
| 23e. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23f. DATE<br><b>Sept. 22, 1980</b>  |  | 23g. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  |  | 23h. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Baltimore Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Loring Byers Funeral Directors, P.A.<br/>8728 Liberty Rd. Randallstown, Maryland 21133</b>   |  |   |  | 25. DATE REC'D. BY REGISTRAR<br><b>SEP 23 1980</b>  |  |   |  |



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 22063

1. FOR  
STATE  
REGISTRAR

REG. NO.

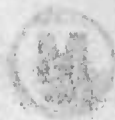
|   |  |  |  |   |   |  |  |  |  |  |
|---|--|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Julia Freda Blackman</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>Sept. 13, 1980</b>              |   |   | 2b. HOUR<br><b>2 P. M.</b>   |  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>May 25, 1904</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Chapel Hill Nursing Home</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |  |
| 13a. STATE<br><b>Md.</b>  |  |  |  |   | 13b. COUNTY<br><b>Talbot</b>  |  | 13c. CITY OR TOWN<br><b>St. Michaels</b>                               |  | 13e. STREET ADDRESS<br><b>River View DR</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>August Forster</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Christine ?</b> |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>   |  |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>213 50 5056</b>                      |  | 17. INFORMANT<br>ADDRESS<br><b>Charles Blackman Ardmore Pa.</b>        |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CVA + Hemiplegia (rt)</b><br><b>436-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Generalized Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Urinary Incontinence - Recaliti</b>   |  |  |  |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-13-</b> 19 <b>76</b> , to <b>9-13-</b> 19 <b>80</b> , that (I) <input checked="" type="checkbox"/> lost<br>saw the deceased alive on <b>9-13-</b> 19 <b>80</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated<br>above, (I <input checked="" type="checkbox"/> did not) view the body after death. |  |  |  |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Cesar Valle Cervero</b> M.D.   |  |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>9-16-80</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CESAR VALLE CAVERO</b>  |  |  |  |   |   | 22e. ADDRESS<br><b>5310 Old Ct. Rd.</b>  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>9-17-80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Mem. Park</b>     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Easton Talbot Md.</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Harry W. Haight</b> ADDRESS<br><b>Sylacoth, Md.</b>  |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 18 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Mary McCreary</b>   |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  | 8 0 2 2 0 6 4      |  |  |
|---|--|---|--|--|--------------------|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  | REG. NO.           |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ruth Bloch   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9 13 80 |  | 2b. HOUR<br>145 AM |  |  |
| 3 SEX<br>FEMALE   |  | 4 RACE<br>WHITE   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>FEB. 8, 1914  |                    | 6 AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>GERMANY  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                    | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.  |  |
| 10 CITY OR TOWN OF DEATH<br>RANDALLSTOWN  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTO. COUNTY GEN. HOSP. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SALES LADY   |                    | 12b. KIND OF BUSINESS OR INDUSTRY<br>RETAIL  |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                    | 13d. STREET ADDRESS<br>3807 MIDHEIGHTS RD. #21215  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>EMANUEL KUNST  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>HELENE KATZKE   |  |  |                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>124-26-5061  |  | 17 INFORMANT ADDRESS<br>MR. JACK BLOCH 4723 DUNCANNON RD. #21208   |                    |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u><br>410 -<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>ACUTE ANTEROSEPTAL INFARCTION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |  |                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |   |  |  |                    |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                    |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                    |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |                    |  |  |
| 22b. SIGNATURE<br>HAFEZ A SYED  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |                    | 22c. DATE SIGNED<br>9/13/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HAFEZ A SYED   |  |   |  | 22e. ADDRESS<br>BALTIMORE COUNTY GENERAL HOSPITAL  |                    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>9-14-80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTIMORE HEBREW   |                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>REISTERSTOWN BALTO. MD   |  |
| 24 FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.<br>NAME ADDRESS<br>6010 REISTERSTOWN RD., BALTO., MD 21215   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 19 1980   |                    | 25b. REGISTRAR'S SIGNATURE<br>Lefsky McQuay  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR  |   | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | 8 0 2 2 0 6 5<br>REG. NO.   |  |
|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>John A. Bobb  |   |   | 2a. DATE OF DEATH<br>September 17, 1980  |   | 2b. HOUR<br>M  |
| 3. SEX<br>Male  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>August 20, 1914   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                           |   |  |
| 10. CITY OR TOWN OF DEATH<br>Glendale   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1137 C. Glendale Rd. # |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret. Security Ger. |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Motors  |
| 13a. STATE<br>Maryland  |   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Glendale  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>1137 C. Glendale Rd.  |
| 14. FATHER'S NAME<br>Unknown  |   |   | 15. MOTHER'S MAIDEN NAME<br>Unknown  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |   | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>WWII  | 17. INFORMANT ADDRESS<br>Mrs. Helen E. Bobb, same as #13e                              |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Renal failure</u><br><u>1579</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Carcinomatosis</u><br>(c) <u>Adenocarcinoma - pancreas</u>  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 months</u><br><u>2 months</u>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 22, 1965</u> to <u>September 17, 1980</u> , that (I) <u>(X)</u> last saw the deceased alive on <u>September 17, 1980</u> , and that in (my) <u>(X)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(X)</u> <u>(did)</u> (did not) view the body after death. |   |   |  |   |  |
| 22b. SIGNATURE<br><u>Donald O. Wood M.D.</u>  |   |   |  | 22c. DATE SIGNED<br><u>9/19/80</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Donald O. Wood M.D.  |   |   |  | 22e. ADDRESS<br>2 Greenmeadow Drive, Timonium 21093   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |   | 23b. DATE<br>9-20-80  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Mem. Park                               |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto, County Maryland   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc. Baltimore, Md. 21214  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>SEP 22 1980   |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>L. J. Ruck</u>   |   |   |  |   |  |

55-2350

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 0 2 2 0 6 6   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Lillian Veronica BOND   |  |   |  | 2b. DATE OF DEATH MONTH DAY YEAR<br>September 20, 1980  |  | 2b. HOUR<br>4:00A   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Aug 19 1899  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hosp |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Secretary   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>ARCO   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Md. Balto.   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>2872 Kentucky Ave.   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Bond   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Alice Kane  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no   |  | 16b. SOCIAL SECURITY NO<br>216-05-2546  |  | 17. INFORMANT ADDRESS<br>Vincent Bond (brother) 6210 Hilltop Ave.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Renal failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(c) <u>Uterine carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>September 17, 1980</u> to <u>September 20, 1980</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>September 20, 1980</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Hattie Faison</i>   |  |   |  | DEGREE<br>MD.   |  | 22c. DATE SIGNED<br>9/20/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Hattie Faison   |  |   |  | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>9/22/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.  |  |
| 24. FUNERAL HOME<br>Schmunek Funeral Home, Inc.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 23 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert H. H. H.</i>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |   |   |  |  |   |  |  |
|---|--|--|---|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Howard E. Boulder</i>                   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>9-13-80</i>         |   |  | 2b. HOUR<br><i>9 A</i> M   |   |  |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>White</i>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>5-25-05</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>75</i> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE<br>STATE OR FOREIGN COUNTRY<br><i>Balto. Md.</i>                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i><br><i>1429 Rosewick Avenue-21037</i> |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto.</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>1429 Rosewick Ave.</i> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Retired</i>                   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Beth Steel</i>           |  |
| 13a. STATE<br><i>Md.</i>  |  |  | 13b. COUNTY<br><i>Balto.</i>                                  |   | 13c. CITY OR TOWN<br><i>Balto.</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Charles Boulder</i>                  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Sarah</i> |   |  | 13e. STREET ADDRESS<br><i>1429 Rosewick Ave.-21237</i>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i> |  |  | 16b. SOCIAL SECURITY NO.<br><i>213-07-3128</i>                |   | 17. INFORMANT<br>ADDRESS<br><i>Mrs. Louise A. Boulder - 1429 Rosewick Ave.-21237</i> |  |   |  |  |

|  |  |   |  |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><i>1 MONTH</i> |  |
| 4149<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <i>CORONARY ARTERY DISEASE</i>           |  |   |  |
| (c) <i>GENERALIZED ARTERIO SCLEROSIS</i>   |  |   |  |

|  |  |  |  |
|--|--|--|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/1/80</i> to <i>9/13/80</i> , that (I) (we) last saw the deceased alive on <i>5/1/80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If two doctors did not view the body after death.) |  |  |  |
| 22b. SIGNATURE<br><i>Robert Fisher</i>   |  | 22c. DATE SIGNED<br><i>9/15/80</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>ROBERT FISHER M.D., F.A.A.F.P.</i>   |  | 22e. ADDRESS<br><i>285 RIDGE ROAD</i>  |  |

|   |  |                             |  |   |  |   |  |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>                           |  | 23b. DATE<br><i>9-16-80</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Parkwood Cm.</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Balto. Md. 21237</i> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>John C. Miller Inc-6415 Belair Rd.-21206</i> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><i>SEP 15 1980</i>       |  | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony McCreedy</i>                 |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the records after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |                       |  |  | 8022068  |  |  |  |
|---|-----------------------|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |                       |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>FREDERICK N. BRISCOE   |                       |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9-1-80  |  | 2b. HOUR<br>6:38 PM  |  |
| 3 SEX<br>M  | 4 RACE<br>B           | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>10-20-07  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.  |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |                       | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY CO. MD.   |  |
| 10 CITY OR TOWN OF DEATH<br>BALTO. CO. BALTO.   |                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>General |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret.   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                       |  |  | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 13a. STATE<br>MD  | 13b. COUNTY<br>BALTO. | 13c. CITY OR TOWN<br>BALTO.  | 13d. STREET ADDRESS<br>501 W. FRANKLIN ST. |  |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Walter BRISCOE   |                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNA BRISCOE  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |                       | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>043-12-3060   |  | 17 INFORMANT<br>ADDRESS<br>SADIE KIRK 4238 NORFOLK AVE.  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARCINOMA OF LUNG<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |                       |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                       |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>NA  |                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                       | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-28, 1980, to 9-1, 1980, that (I) (we) last saw the deceased alive on 9-1, 1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                            |                       |  |  |  |  |  |  |
| 22b. SIGNATURE<br>VANDYACK V. REDDY   |                       | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>      |  | 22c. DATE SIGNED<br>9-1-80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>VANDYACK V. REDDY  |                       | 22e. ADDRESS<br>BALTIMORE COUNTY GEN HOSPITAL<br>RANDALLSTOWN, MD.   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |                       | 23b. DATE<br>9-5-80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. Auburn Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. BALTO. MD   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>BROWN/THOMPSON   |                       | ADDRESS<br>1913 W. BALTO ST.   |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 3 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>R. J. Thompson   |  |

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1/10/1971  
The following is a list of the names of the persons who have been named in the above mentioned document.

1. Mr. J. H. Smith  
2. Mr. J. H. Smith  
3. Mr. J. H. Smith  
4. Mr. J. H. Smith  
5. Mr. J. H. Smith  
6. Mr. J. H. Smith  
7. Mr. J. H. Smith  
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11. Mr. J. H. Smith  
12. Mr. J. H. Smith  
13. Mr. J. H. Smith  
14. Mr. J. H. Smith  
15. Mr. J. H. Smith  
16. Mr. J. H. Smith  
17. Mr. J. H. Smith  
18. Mr. J. H. Smith  
19. Mr. J. H. Smith  
20. Mr. J. H. Smith

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Frank A. Broda</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 4 80</b>                               |  | 2b. HOUR<br><b>M</b>   |
| 3 SEX<br><b>Male</b>  | 4 RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>October 13, 1909</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b><br>YRS MONTHS DAYS HOURS MIN.     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County,</b> MD.           |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Rougher</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel Co.</b>  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Essex</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John A. Broda</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Kurlinski</b>        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216 03 5227</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Leona Broda (Wife) Same</b>                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arterio Sclerotic Cardio Vascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-16</b> , 19 <b>80</b> , to <b>9-4</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>5-20</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE<br><b>L. G. Milley</b><br>THE PHYSICIAN'S NAME (TYPE OR PRINT)   |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>9-4-80</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>Sept. 6, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Cemetery</b>              |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City, Maryland</b>   |  | 23e. DATE REC'D. BY REGISTRAR<br><b>SEP 8 1980</b>  |  |  |  |
| 23f. REGISTRAR'S SIGNATURE<br><b>Prudzinski Funeral Home PA 1407 Old Eastern Ave.</b>   |  | 23g. REGISTRAR'S SIGNATURE<br><b>Prudzinski Funeral Home PA 1407 Old Eastern Ave.</b>   |  |  |  |

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1

MEDICAL CERTIFICATION

9  
9



FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

22070

|  |         |   |                   |  |  |   |  |                                   |  |   |  |
|--|---------|---|-------------------|--|--|---|--|-----------------------------------|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |   |                   | 2a. DATE KNOWN OF DEATH  |  |   |  | 2b. HOUR                          |  |   |  |
| David Robert Brooke  |         |   |                   | XX 9 28 1980   |  |   |  | M                                 |  |   |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  | 6. AGE (IN YEARS) | IF UNDER 1 YR.   |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD          |  | 2d. HOUR  |  |
| Male   | White   | 8 7 1953  | 27 YRS.           |  |  |   |  | 9 28 1980                         |  | 1:45A   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                                   |  |   |  |
| MARYLAND   |         | U.S.A.  |                   |  |  | Baltimore County MD.  |  |                                   |  |   |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |   |  |
| U.S.A.   |         | I-695 between Belair Rd nr. Putty Hill  |                   |  |  | SALES   |  | FOX CHEV.                         |  |   |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |         |   |                   | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS               |  |   |  |
| MARYLAND   |         |   |                   | BALTIMORE  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | 1955 QUENTIN RD.                  |  |   |  |
| 14. FATHER'S NAME  |         |   |                   | 15. MOTHER'S MAIDEN NAME   |  |   |  |                                   |  |   |  |
| ROBERT BROOKE  |         |   |                   | BARBARA CLAYTON  |  |   |  |                                   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         |   |                   | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  |                                   |  |   |  |
| NO   |         |   |                   | 339464036  |  | KAREN BROOKE 1955 QUENTIN RD  |  |                                   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |   |                   |  |  |   |  |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| PART 1 DEATH WAS CAUSED BY:  |         |   |                   |  |  |   |  |                                   |  |   |  |
| IMMEDIATE CAUSE (a) Multiple injuries  |         |   |                   |  |  |   |  |                                   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |                   |  |  |   |  |                                   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |         |   |                   |  |  |   |  |                                   |  |   |  |
| (b)  |         |   |                   |  |  |   |  |                                   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |                   |  |  |   |  |                                   |  |   |  |
| (c)  |         |   |                   |  |  |   |  |                                   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |   |                   |  |  |   |  |                                   |  |   |  |
| 19a. DATE OF OPERATION   |         |   |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |                                   |  | 20. AUTOPSY?  |  |
|  |         |   |                   |  |  |   |  |                                   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |   |                   | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                   |  |   |  |
|  |         |   |                   | 2:45 PM 9 28 1980  |  | driver in auto/auto impact  |  |                                   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |         |   |                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION   |  |                                   |  |   |  |
|  |         |   |                   | street   |  | I-695 between Belair Rd nr. Putty Hill, Balto, MD                             |  |                                   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |   |                   |  |  |   |  |                                   |  |   |  |
| ACTUAL SIGNATURE   |         |   |                   | TITLE (SPECIFY)  |  |   |  | DATE SIGNED                       |  |   |  |
| Thomas D. Smith  |         |   |                   | M.D. Deputy Chief  |  |   |  | 9/28/80                           |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |   |                   | ADDRESS  |  |   |  |                                   |  |   |  |
| Thomas D. Smith, M.D.  |         |   |                   | 111 Penn St. Balto., MD.   |  |   |  |                                   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL  |         | 23b. DATE   |                   | 23c. NAME OF CEMETERY OR CREMATORY   |  |   |  | 23d. LOCATION                     |  |   |  |
| BURIAL   |         | 10/1/1980   |                   | SACRED HEART JESUS   |  |   |  | BALTIMORE, MD.                    |  |   |  |
| 24. FUNERAL DIRECTOR   |         |   |                   | 25a. DATE REC'D. BY REGISTRAR  |  |   |  | 25b. REGISTRAR'S SIGNATURE        |  |   |  |
| Raymond L. Kackorowski   |         |   |                   | 2525 FLEET ST  |  |   |  | SEP 30 1980                       |  |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY POST-MORTEM EXAMINATION IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |                  |                  |  |  |  |  |   |                |                                      |  |   |  |   |  |                                      |  |  |  |  |  |
|--|--|------------------|------------------|--|--|--|--|---|----------------|--------------------------------------|--|---|--|---|--|--------------------------------------|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  | FIRST<br>Donnise |  |  | MIDDLE<br>Dinque   |  |   | LAST<br>Brooks |                                      |  | 2a. DATE KNOWN<br>OF DEATH<br>ESTI-<br>MATED  |  |   | <input checked="" type="checkbox"/> MONTH<br>9 27 1980 |                                      |  | 2b. HOUR<br>M<br>5:08P                                 |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black |                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 17 80  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>YRS. 2 10                    |  | IF UNDER 1 YR.<br>MONTHS DAYS   |                | IF UNDER 24 HRS.<br>HOURS MIN        |  | 7c. DATE<br>PRONOUNCED<br>DEAD<br>9 27 1980   |  |   | 2d. HOUR<br>M  |                                      |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>MD   |  |                  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                |                                      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                                   |  |   |  |                                      |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Essex   |  |                  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |  |  |   |                |                                      |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                                |  |   |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY |  |  |  |  |  |
| 13a. STATE<br>MD   |  |                  |                  | 13b. COUNTY  |  |  |  | 13c. CITY OR TOWN<br>Baltimore  |                |                                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2630 Kent St.  |  |                                      |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Donald E. Brooks   |  |                  |                  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Gloria J. Bundley |  |   |                |                                      |  |   |  |   |  |                                      |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                  |                  | (IF YES, GIVE WAR OR DATES)  |  |  |  | 16b. SOCIAL SECURITY NO.<br>N/A   |                |                                      |  | 17. INFORMANT<br>ADDRESS<br>Gloria Bundley 2630 Kent St.  |  |   |  |                                      |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sudden Infant Death Syndrome</u><br>7980<br>Canditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                  |                  |  |  |  |  |   |                |                                      |  |   |  |   |  |                                      |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH        |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |                  |  |  |  |  |   |                |                                      |  |   |  |   |  |                                      |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |                |                                      |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                      |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                |                                      |  |   |  |   |  |                                      |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |                  |                  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                |                                      |  |   |  |   |  |                                      |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion<br>death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |                  |  |  |  |  |   |                |                                      |  |   |  |   |  |                                      |  |  |  |  |  |
| ACTUAL<br>SIGNATURE<br><i>Thomas D. Smith</i>  |  |                  |                  |  |  |  |  |   |                | TITLE (SPECIFY)<br>M.D. Deputy Chief |  |   |  | DATE<br>SIGNED 9/30/80  |  |                                      |  |  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, M.D.  |  |                  |                  |  |  |  |  |   |                | ADDRESS<br>111 Penn St. Balto., MD.  |  |   |  |   |  |                                      |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                  |                  | 23b. DATE<br>10/2/80   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cem.   |                |                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD                                  |  |   |  |                                      |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H   |  |                  |                  |  |  |  |  |   |                | ADDRESS<br>1101 E. North Ave.        |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 30 1980  |  |                                      |  | 25b. REGISTRAR'S SIGNATURE<br><i>Patricia H. Brady</i> |  |  |  |



1 X 2 51 0

RECEIVED - DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C. 20250

(M)

*Handwritten signature*

0821 0 932



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours at the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMM-16 25M  
(VRS 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 0 7 2

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |   |  |  |   |  |  |       |
|--|--|--|---|--|--|---|--|--|-------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Edward Brown</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9-14-80</b> |  |  | 2b. HOUR<br><b>2:30 A.</b>  |  |  |       |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>Black</b>   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8-22-05</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>✓</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore county</b> MD.                              |  |  |       |
| 10 CITY OR TOWN OF DEATH<br><b>Towson, Md</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Multi-Medical Nursing Home</b> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Steel Worker</b>         |  | 12b. KIND OF BUSINESS OR INDUSTRY  |       |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>301 McMechen St.</b>   |       |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Brown</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Harriett Graham</b>  |   |  |  |   |  |  |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO<br><b>212-01-8103</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Bertina Brown 301 McMechen St.</b>  |  |   |  |  |       |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic squamous cell carcinoma</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Squamous Cell Carcinoma of the Lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>9 mo</b> |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>9 mo</b>  |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Anemia</b>   |  |  |   |  |  |   |  |  |       |
| 19a. DATE OF OPERATION<br><b>N/A</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>N/A</b>   |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |       |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>N/A</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>N/A</b>   |  |   |  |  |       |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>N/A</b>   |   | 21f. LOCATION<br>STREET<br><b>N/A</b>  |  | CITY OR TOWN  |  | COUNTY   | STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 7/80</b> to <b>Sept 14/80</b> , that (I) (we) lost<br>saw the deceased <b>Sept 12/80</b> and that in my opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did not) view the body after death.                 |  |  |   |  |  |   |  |  |       |
| 22b. SIGNATURE<br><b>Alfred J. [Signature]</b>   |  |  |   | DEGREE   |  |   |  | 22c. DATE SIGNED<br><b>9/14/80</b>   |       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. H. Jankowski, MD</b>  |  |  |   | 22e. ADDRESS<br><b>22 So Greene ST BALT Md 21201</b>   |  |   |  |  |       |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>9-18-80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN<br><b>Anne Arundel</b>  |  | COUNTY   | STATE |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Carlton C. Douglass</b>   |  |  |   | ADDRESS<br><b>1012 Penn Ave</b>  |  | 25a. DATE REC'D BY REGISTRAR<br><b>SEP 15 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |       |

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*[Faint, mostly illegible handwritten text covering the main body of the page. Some words like "received" and "information" are faintly visible.]*

*[Handwritten signature or initials in the bottom left corner.]*

SEP 12 1960

*[Faint handwritten text at the bottom right, possibly a date or reference number.]*

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |  |  |   |  |  |   |  |  |   |   |  |  |  |  |  |  |  |          |  |  |
|---|--|--|--|--|--|---|--|--|---|--|--|---|---|--|--|--|--|--|--|--|----------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST<br>Loretta   |  |  | MIDDLE<br>Jean  |  |  | LAST<br>Brown   |  |  | 2b. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR |   |  | 2d. HOUR   |  |  |  |  |  |          |  |  |
| 3. SEX  |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)  |  |  | IF UNDER 1 YR.<br>MONTHS DAYS   |   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR |  |  | 7d. HOUR |  |  |
| Female  |  |  | Black  |  |  | MAR. 23 1955  |  |  | 25 YRS.   |  |  |   |   |  |  |  |  | 9 28 1980                                  |  |  | 3:19A    |  |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7c. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |   |   |  |  |  |  |  |  |  |          |  |  |
| MARYLAND  |  |  | US of A  |  |  |   |  |  | Baltimore County.   |  |  |   |   |  |  |  |  |  |  |  |          |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |   |   |  |  |  |  |  |  |  |          |  |  |
| Towson  |  |  | St. Joseph's Hospital  |  |  | ORDER CLERK   |  |  | BON - KAY   |  |  |   |   |  |  |  |  |  |  |  |          |  |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  | 13b. STATE   |  |  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS   |   |  |  |  |  |  |  |  |          |  |  |
| MARYLAND  |  |  |  |  |  | BALTIMORE   |  |  |   |  |  | 5411 SARRIL RD. APT. F  |   |  |  |  |  |  |  |  |          |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  |  |   |  |  |   |  |  |   |   |  |  |  |  |  |  |  |          |  |  |
| PHILLIP J. REED   |  |  | CAROLYN PEARSON  |  |  |   |  |  |   |  |  |   |   |  |  |  |  |  |  |  |          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT   |  |  | ADDRESS   |  |  |   |   |  |  |  |  |  |  |  |          |  |  |
| NO  |  |  | 217 64 7239  |  |  | MRS. ROBERTA PALABON  |  |  | 3912 CRANSTON AVE.  |  |  |   |   |  |  |  |  |  |  |  |          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple injuries</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |   |  |  |   |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |          |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |  |  |   |  |  |   |  |  |   |   |  |  |  |  |  |  |  |          |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |   |  |  |   |  |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |          |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |  |  |   |   |  |  |  |  |  |  |  |          |  |  |
| 12:45xx 9 28 1980   |  |  |  |  |  | passenger in auto/auto impact   |  |  |   |  |  |   |   |  |  |  |  |  |  |  |          |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |   |   |  |  |  |  |  |  |  |          |  |  |
|   |  |  | beltway  |  |  | I-695 between Belair & Harford Rds. Balto., MD  |  |  |   |  |  |   |   |  |  |  |  |  |  |  |          |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |  |  |  |  |   |  |  |   |  |  |   |   |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |  |  |  |  |          |  |  |
| ACTUAL SIGNATURE  |  |  | TITLE (SPECIFY)  |  |  |   |  |  |   |  |  |   | DATE SIGNED   |  |  |  |  |  |  |  |          |  |  |
| Thomas D. Smith, M.D.   |  |  | Deputy Chief   |  |  |   |  |  |   |  |  |   | 9/28/80   |  |  |  |  |  |  |  |          |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |  | ADDRESS  |  |  |   |  |  |   |  |  |   |   |  |  |  |  |  |  |  |          |  |  |
| Thomas D. Smith, M.D.   |  |  | 111 Penn St. Balto., MD.   |  |  |   |  |  |   |  |  |   |   |  |  |  |  |  |  |  |          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |   |   |  |  |  |  |  |  |  |          |  |  |
| BURIAL  |  |  | 10/2/80  |  |  | CEDAR HILL CEMETERY   |  |  | BALTIMORE (A A Co.) MD.   |  |  |   |   |  |  |  |  |  |  |  |          |  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |  | ADDRESS  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |   |   |  |  |  |  |  |  |  |          |  |  |
| LEWIS T. GWYNN  |  |  | 4517 PARK HEIGHTS AVENUE   |  |  | OCT 2 1980  |  |  | L. T. Gwynn   |  |  |   |   |  |  |  |  |  |  |  |          |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 0 2 2 0 7 4  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.   |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>David J. Burgess  |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br>9 28 80   |  | 2b HOUR<br>M   |  |
| 3 SEX<br>MALE  |  | 4 RACE<br>CAUC.  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>2/4/90   |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS.<br>90  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. COUNTY MD.   |  |
| 10 CITY OR TOWN OF DEATH<br>BALTO. CO.   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTO. CO. GEN. HOSP. |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |
| 13a STATE<br>MD  |  | 13b COUNTY<br>BALTO.   |  | 13c CITY OR TOWN<br>OWINGS MILLS   |  | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>? ? ?  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>? ? ?   |  | 13e STREET ADDRESS<br>428 PLEASANT HILL RD.  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b SOCIAL SECURITY NO.<br>213-05-0439A  |  | 17 INFORMANT ADDRESS<br>NIECE  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>5750<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <u>acute respiratory distress</u><br>(c) <u>aspiration pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a DATE OF OPERATION<br>9/23/80   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br>acute cholelithiasis  |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from 6PM 9/27 19 80 to 1234AM 9/28 19 80, that (I) (we) lost the deceased alive on 1230AM 9/28 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.  |  |  |  |  |  |  |  |
| 22b SIGNATURE<br>Juan C. Ruffier   |  |  |  | DEGREE<br>MD   |  | 22c DATE SIGNED<br>9/28/80   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>JUAN CARLOS RUFFIER  |  |  |  | 22e ADDRESS  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b DATE<br>9/30/80  |  | 23c NAME OF CEMETERY OR CREMATORY<br>ST. MARY'S  |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br>BALTO. MD.   |  |
| 24 FUNERAL DIRECTOR NAME<br>Paul E. Charney  |  |  |  | ADDRESS<br>3617 Chantrel Ave   |  | 25 DATE REC'D. BY REGISTRAR<br>SEP 30 1980   |  |
|  |  |  |  | 26 REGISTRAR'S SIGNATURE<br>[Signature]  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 2 0 7 5  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |  |  |  |  |   |   |  |
|---|--|---|---|--|--|--|--|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>CHARLES CLAYTON BURNHAM</b>  |  |   | 2a DATE OF DEATH MONTH DAY YEAR<br><b>September 24, 1980</b>        |  |  | 2b HOUR P M<br><b>6 M</b>  |  |   |   |  |
| 3. SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>  |   | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>Jan. 17, 1911</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS                    |  | 7 IF UNDER 1 YEAR IF UNDER 24 HRS<br>MONTHS DAYS HOURS MIN. |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD. |  |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>121 Oak Drive</b> |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mixologist</b>   |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>                 |  |   |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>                                     |  | 13c. CITY OR TOWN<br><b>Catonsville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |   | 13e. STREET ADDRESS<br><b>121 Oak Drive</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Charles C. Burnham</b>  |  |   | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary F. Barrett</b> |  |  |  |  |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>  |  |   | 16b SOCIAL SECURITY NO.<br><b>217-03-4286</b>                       |  | 17 INFORMANT ADDRESS<br><b>Frank M. Burnham, 121 Oak Drive 21228</b>                     |  |  |   |   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic Ca of Liver</b><br><b>1541</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ca of Rectum</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 mo.</b><br><b>12 mo</b> |  |   |   |  |  |  |  |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |   |  |  |  |  |   |   |  |
| 19a. DATE OF OPERATION<br><b>9/24</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Ca of Rectum</b>   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>6 P.M. Sept 24 1980</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MAR 1965</b> to <b>9/24 1980</b> , that (I) (we) last saw the deceased alive on <b>9/22 1980</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.  |  |   |   |  |  |  |  |   |   |  |
| 22b. SIGNATURE<br><b>John C. Pound MD</b>   |  |   |   |  | DEGREE<br><b>MD</b>  |  |  | 22c. DATE SIGNED<br><b>9/25/80</b>                          |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. John C. Pound</b>   |  |   |   |  | 22e. ADDRESS<br><b>2108 Edmondson Ave.<br/>100 X N. Pikesville Rd., Balto., Md 21228</b> |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>9/27/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Stone Chapel Meth. Cem.</b>   |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Pikesville, Balto., Md.</b>  |   |   |  |
| 24 FUNERAL DIRECTOR NAME<br><b>Witzke Funeral Home of Catonsville, P.A. 21228</b>   |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 29 1980</b>                                      |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |   |  |

MEDICAL CERTIFICATION

4004 BP



35215

080

UNITED STATES DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.

43



*Handwritten signature or initials*

000 85432

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   |  |   |   |  |  | 8022076                                      |  |
|---|--|---|---|---|--|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |   |   | REG. NO.   |   |   |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Franklin Pierce Busch, Jr.   |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>September 8, 1980                          |   |   |  | 2b. HOUR<br>M  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>01 26 07   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.  |   | 7. # UNDER 1 YEAR<br>MONTHS DAYS   |  | 7b. # UNDER 24 HRS<br>HOURS MIN.             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                           |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>7005 Lachland Circle Apt. L |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>District Freight Agent |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Davidson Transfer   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>7005 Lachland Circle Apt. L   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Franklin P. Busch, Sr.   |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Lillie Parks                     |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  |   | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>705-10-4512 |   | 17. INFORMANT ADDRESS<br>Mrs. Irma B. Busch Same as #13.                       |   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line of (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>METASTATIC DISEASE</u><br>185-<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA OF PROSTATE</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Renal Failure, anemia, Heart Failure</u>  |  |   |   |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |   |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>April 10, 1978</u> , to <u>Sept. 8, 1980</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>Sept. 5, 1980</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death. |  |   |   |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><i>Jamshid Hamed</i>  |  |   |   |   | DEGREE<br>M. D.  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>9-8-80                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jamshid Hamed, M.D.  |  |   |   |   | 22e. ADDRESS<br>204 E. Joppa Road Towson, Md. 21204                            |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Entombment   |  |   | 23b. DATE<br>Sept. 11, 1980   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Mem. Park                       |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Parkville Baltimore Md.                              |  | 23e. DATE REC'D BY REGISTRAR   |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Ruck Towson Funeral Home, Inc.   |  |   |   |   | ADDRESS<br>1050 York Road Towson, Md. 21204                                    |   | 25a. DATE REC'D BY REGISTRAR<br>SEP 9 1980  |  |  |  |  |

06-B-018

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 0 2 2 0 7 7   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>WALTER A. BUSENIUS Sr.</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>9/27/80</b>  |  | 2b. HOUR<br><b>9:45P<sup>M</sup></b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Nov. 12, 1908</b>   |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>71</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC--6701 N. CHARLES ST.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Plumbing Inspector</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. County</b>  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Parkville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Walter O. Busenius</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Elizabeth Otto</b>  |  | 13e. STREET ADDRESS<br><b>8711 Loch Bend Drive</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215 03 7151</b>   |  | 17. INFORMANT ADDRESS<br><b>Walter A. Busenius, Jr. Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>EXTENSIVE BRAIN INFARCTION</b><br><b>4349</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that <del>the</del> (this hospital) attended the deceased from <b>9/14/</b> 19 <b>80</b> , to <b>9/27</b> 19 <b>80</b> , that <del>the</del> (we) last saw the deceased alive on <b>9/27/</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <del>the</del> (we) (did) (did not) view the body after death.                     |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>moh. Tabbaa</i>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>9/27/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MOHAMMED TABBA</b>  |  |  |  | 22e. ADDRESS<br><b>GBMC--6701 N. CHARLES ST.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>10/1/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Balto., County, Md.</b>  |  |
| 24. FUNERAL DIRECTOR <b>Henry W. Jenkins &amp; Sons Co.</b><br>NAME ADDRESS<br><b>4905 York Road Balto., Md. 21212</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 30 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert McCreedy</i>   |  |

BP



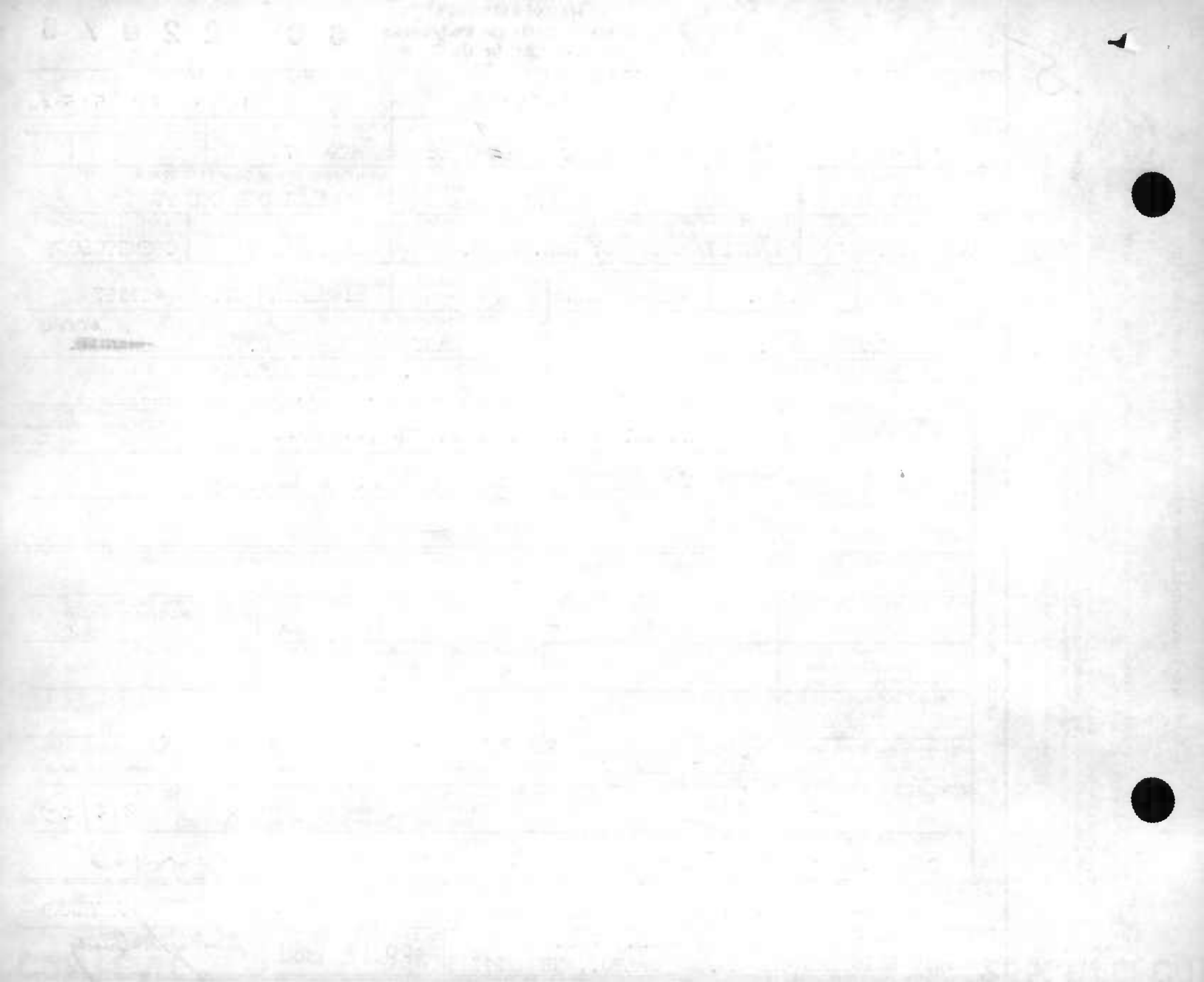
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 0 2 2 0 7 8   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ETHEL MARIE CAPLAN   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9 8 80   |  | 2b. HOUR<br>5:50 AM   |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>CAUCASIAN   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 5 02  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>XXX 78 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD   |  |
| 10. CITY OR TOWN OF DEATH<br>RANDALLSTOWN   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE COUNTY GEN. HOSP. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MANICURIST  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>COSMETOLOGY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND   |  |  |  | 13b. COUNTY<br>BALTO.   |  | 13c. CITY OR TOWN<br>OWINGS MILLS   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM F. PARKER   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY E. NORRIS   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-40-8974   |  | 17. INFORMANT<br>MR. MICHAEL CAPLAN   |  | ADDRESS<br>2 TENTMILL LA., APT. I #21208  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myo Cardial Infarction</u><br><u>410-</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>2 Cardiac Arrhythmias + Arrest.</u><br>DUE TO OR AS A CONSEQUENCE OF<br>(c) <u>-</u><br>DUE TO OR AS A CONSEQUENCE OF |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>-</u>  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><u>-</u>  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><u>-</u>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8-27-</u> 19 <u>80</u> to <u>9-8-</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>9-8-</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22a. SIGNATURE<br><u>S. Soliman</u>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>9/8/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. SUDHIR. PATEL  |  |  |  | 22e. ADDRESS<br>Bal. County Gen Hospital  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>SEPT. 9, 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>HEBREW YOUNG MEN  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND  |  |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.<br>NAME ADDRESS<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 11 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert McCreedy</u>  |  |





1. FOR  
STATE  
REGISTRAR

|  |  |   |  |  |   |   |  |  |   |  |
|--|--|---|--|--|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Antonio Cappalone</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 3/80</b>               |  |   | 2b. HOUR<br><b>6:40 PM</b>  |  |  |   |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10-17-1891</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Italy</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Forest Haven Nursing Home</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><b>Md</b>  |  |   | 13b. COUNTY<br><b>Catonsville, Balto.</b>                              |  |   | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>        |  |   | 13e. STREET ADDRESS<br><b>315 Ingleside Ave</b>   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |   | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>WW #1</b> |  |   | 17 INFORMANT<br><b>RECORDS OF FOREST HAVEN Nsg Home</b>   |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Stroke</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ASCD</b><br>(c) <b>Stroke</b>  |  |   | 18b. SOCIAL SECURITY NO<br><b>217-54-7562</b>                          |  |   | ADDRESS <b>315 Ingleside Ave Balto. Md. 21228</b>   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |   |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>100</b> 19 <b>78</b> to <b>9-3</b> 19 <b>80</b> that (I) (we) last saw the deceased alive on <b>8-19</b> 19 <b>80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Harold B Bob</b>  |  |   | 22c. DEGREE<br><b>MD</b>   |  |   | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22e. DATE SIGNED<br><b>9-4-80</b>  |   |  |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Harold B Bob</b>   |  |   | 22g. ADDRESS<br><b>7220 Park Heights</b>                               |  |   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>09/08/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARBUTUS MEM PARK</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ARBUTUS BALTO Md.</b> |  |   |  |
| 24 FUNERAL DIRECTOR<br><b>MARSHALL W JONES, JR/4101</b>  |  |   | 24b. ADDRESS<br><b>EDMONDSON AVE</b>                                   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 8 1980</b>  |  | 25b. RECEIVED BY<br><b>[Signature]</b>   |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the death certificate must be filed within 72 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 80 22080   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>CHARLES H. CARMINE</b>  |  |  |  | 2b. HOUR<br><b>1:20 AM</b>  |  |   |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>JAN 19 1894</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>86</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CO</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Ruxton</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MANOR CARE RUXTON</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CARPENTER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SELF EMP.</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>BALTO</b> 13c. CITY OR TOWN <b>PHOENIX</b>  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>Poplar Hill Rd</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>CHARLES H. CARMINE</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ELLA COLLISON</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-03-7781</b>   |  | 17. INFORMANT ADDRESS<br><b>Family Records</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Anoxia</b>  |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>acute</b> |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br><b>4292</b>   |  |  |  |   |  |   | <b>&gt; 5 yrs.</b>   |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD &amp; C.B.S.</b>   |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/23</b> 19 <b>75</b> to <b>7/20</b> 19 <b>80</b> , that (I) <del>was</del> last saw the deceased alive on <b>9/26</b> 19 <b>80</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Richard Maffezzoli</b>  |  |  |  | DEGREE  |  | 22c. DATE SIGNED<br><b>9/23/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD MAFFEZZOLI</b>   |  |  |  | 22e. ADDRESS<br><b>1205 YORK RD LUTHERVILLE, MD 21043</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>9-22-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>POPULAR HILL CEM</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>PHOENIX BALTO MD</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>EVANS FUNERAL CHAPEL</b>   |  |  |  | ADDRESS<br><b>8800 HARTFORD RD</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 6 1980</b>  |  |
|  |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

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|---|--|--|--|---|--|--|---------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Nanci C. CARNES</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 24 1980</b>            |   |  | 2b. HOUR<br>M<br><b>11</b>   |                                       |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MARCH 18 1947</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>33</b> YRS   |                                       | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN   |  |
| 7a. BIRTHPLACE<br>STATE OR FOREIGN COUNTRY<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD   |                                       |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Parkville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1807 TRENNLEIGH ROAD</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Benefit Auth.</b>   |                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Social Security</b>  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  |  |   | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Parkville</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert N. Blackburn</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Glenora M. Bruckisch</b> |  |                                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-48-4293</b>  |  | 17. INFORMANT<br><b>FATHER</b>  |  | ADDRESS<br><b>Balto., Md. 21234</b>  |                                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Malignant Fibrous Histiocytoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>MALIGNANT FIBROUS HISTIOCYTOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>HISTIOCYTOMA</b>                        |  |  |  |   |  |  |                                       |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |                                       |  |  |
| 19a. DATE OF OPERATION<br><b>9/28/80</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>7:30 9 1980</b>  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                       |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>2435 W. Belvedere Ave., Baltimore, Maryland</b>  |                                       |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/30/80</b> to <b>9/24/80</b> , that (I) (we) last saw the deceased alive on <b>9/24/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (and) did not view the body after death, so state.) |  |  |  |   |  |  |                                       |  |  |
| THE SIGNATURE<br><b>P. Leonard Lichtenfeld</b>  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                       | 22c. DATE SIGNED<br><b>9/25/80</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  |  |  |   |  | 23b. DATE<br><b>9/27/80</b>  |                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 25 1980</b>  |                                       | 25b. REGISTRAR'S SIGNATURE<br><b>Victory M. M...</b>   |  |

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |  |  |  |  |  | 8 0 2 2 0 8 2 |  |
|--|--|--|---|---|--|--|--|--|--|---------------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |   |   |  |  |  |  |  |               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Walter P Carrion</b>  |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>September 20 1980</b>           |  |  | 2b. HOUR<br><b>8:30AM</b>  |  |               |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><b>October 14, 1895</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>  |  |  |  |               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Josephs Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Boiler Maker B&amp;O RR</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  | 13a. STATE<br><b>Maryland</b>             |   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Overlea</b>  |  |               |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 13e. STREET ADDRESS<br><b>3 Manor Ave</b> |   |  |  |  |  |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Philip Carrion</b>  |  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Adella McMahon</b> |  |  |  |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW 11</b>  |   | 17. INFORMANT<br><b>Mr Walter J Carrion</b>   |  | ADDRESS <b>Columbia, Md</b><br><b>6423 Amherst Ave</b>   |  |  |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the Gall Bladder</b><br><b>1560</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>months</b>  |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |  |  |  |  |  |               |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>9-1 P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |               |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>9-1</b> 19 <b>80</b> to <b>9-20</b> 19 <b>80</b> , that (1) (we) lost<br>saw the deceased alive on <b>9-20</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (or we did) (did not) view the body after death.                          |  |  |   |   |  |  |  |  |  |               |  |
| 22b. SIGNATURE<br><b>Robert E. Stoner</b>  |  |  |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>9-20-80</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert E. Stoner</b>   |  |  |   | 22e. ADDRESS<br><b>714 York Rd. Towson 21204</b>  |  |  |  |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>9/23/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St Joseph</b>  |  | 23d. LOCATION<br><b>Fullerton Baltimore MD</b>   |  |  |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore Maryland</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 22 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>L. J. Ruck</b>  |  |  |  |               |  |



11

4402 BP





4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours of the death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |   |  |  |
|---|--|---|--|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |   | 8 0 2 2 0 8 3<br>REG. NO.  |   |  |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST MIDDLE LAST<br><b>BILLIE E. CARROLL</b>                          |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>September 21, 1980</b>               |  | 2b. HOUR<br><b>4:30 P.M.</b>                                   |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>April 2, 1912</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cockeysville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1 Firefly Circle Apt. D</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>Saleslady</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Mutlzler's</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Cockeysville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET ADDRESS<br><b>1 Firefly Circle</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>August C. Mattes</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Alma Collins</b>   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>218-22-5789</b>  |  | 17. INFORMANT ADDRESS<br><b>Mr. John H. Carroll 1 Firefly Circle Apt. D</b>  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR COLLAPSE</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARCINOMA OF COLON, METASTATIC.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1 YEAR</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 MIN.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>OCT. 19 80</b> , to <b>SEPT 21 19 80</b> , that (I) (we) saw the deceased alive on <b>SEPT 12 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Samuel I. O'Mansky</b>   |  |   | DEGREE<br><b>M.D.</b>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/><br>DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>Sept 22 1980</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Samuel I. O'Mansky, M.D.</b>  |  |   | 22e. ADDRESS<br><b>8405 Loch Raven Blvd.</b>                           |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>9-25-1980</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville, Maryland</b> |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Ruck Towson Funeral Home, Inc. Towson, Maryland</b>   |  |   | ADDRESS<br><b>1050 York Road</b>                                       |   | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 24 1980</b>                            |  | 25b. REGISTRAR'S SIGNATURE<br><b>Richard McHenry</b>                        |  |  |

80-55-80



*[Faint, mostly illegible text and markings covering the majority of the page, including horizontal lines and scattered characters.]*

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

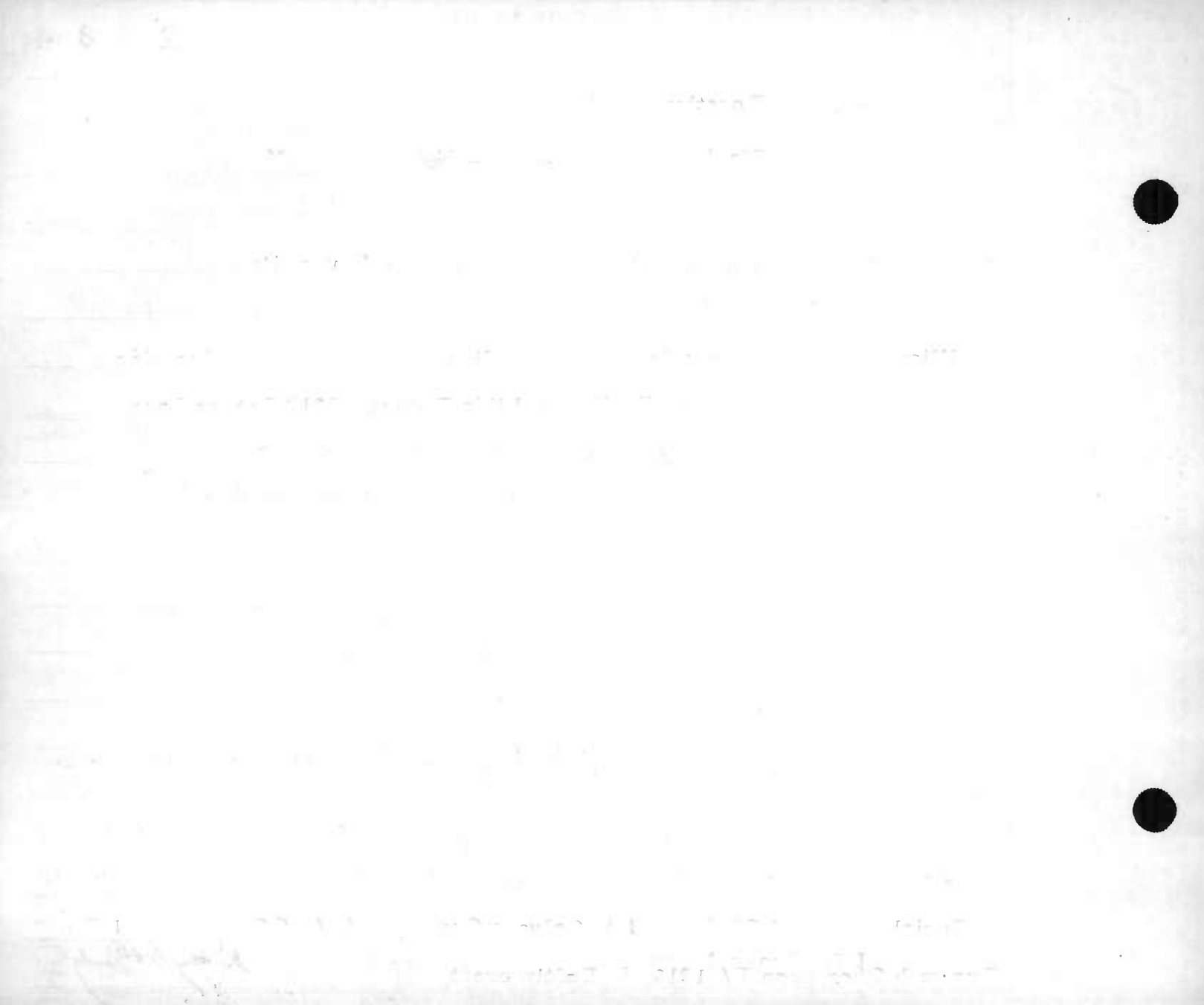
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REG. NO.

|  |  |  |  |  |   |  |  |  |                                       |   |  |
|--|--|--|--|--|---|--|--|--|---------------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Mary Dorothy Carter</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>25</b> YEAR <b>80</b>       |  |   | 2b. HOUR<br><b>7:55am</b>  |  |  |                                       |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>15</b> YEAR <b>84</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>96</b> YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |                                       | 8. IF UNDER 24 HRS<br>HOURS <b></b> MIN <b></b> |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 9c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |  |                                       |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Garrison, MD</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Garrison Valley Center, Inc.</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                                       |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b>   |  |  |  | 13b. CITY OR TOWN<br><b>Glen Burnie</b>  |   | 13c. STREET ADDRESS<br><b>7319 Dotson Lane</b>   |  |  |                                       |   |  |
| 14. FATHER'S NAME<br>FIRST <b>William</b> MIDDLE <b></b> LAST <b>Snowden</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Alice</b> MIDDLE <b></b> LAST <b>Snowden</b>  |   |  |  |  |                                       |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-58-9474</b>   |  | 17. INFORMANT<br><b>Hilda Dorsey</b>   |   |  |  | ADDRESS<br><b>7319 Dotson Lane</b>   |                                       |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of Stomach</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |  |   |  |  |  |                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |   |  |  |  |                                       |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                       |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |                                       |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |                                       |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March</b> 19 <b>1977</b> to <b>Sept 25</b> 19 <b>80</b> , that <b>we</b> last saw the deceased alive on <b>18 Sept</b> 19 <b>80</b> , and that in <b>my</b> (own) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.    |  |  |  |  |   |  |  |  |                                       |   |  |
| 22b. SIGNATURE<br><b>Lawrence Boas</b>   |  |  | DEGREE   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>Sept 25 80</b> |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lawrence Boas MD</b>   |  |  | 22e. ADDRESS<br><b>50 SCOTT AVE RD Cockeysville MD</b>                 |  |   |  |  |  |                                       |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>9-29-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem.</b> |  |  | 23d. LOCATION<br>CITY OR TOWN <b>A. A. CO.</b> COUNTY <b>2080</b> STATE <b>MD.</b>   |                                       |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>I. L. Brown &amp; Son</b><br><b>Brown &amp; Thompson PA 1913 W. Baltimore St</b>   |  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 29 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCready</b>  |                                       |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 0 2 2 0 8 5  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>William E. Cavalier  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>9-11-80  |  | 2b. HOUR<br>9:45 P.M.  |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>5-16-1906  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto. Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Stat of Md.   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13a. STREET ADDRESS<br>4906 Crenshaw Avenue-21206  |  |  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Balto.  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Ouida Cavalier   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Ella V. Counabaugh   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>219-03-5423   |  | 17. INFORMANT ADDRESS<br>Mrs. Melva C. Cavalier - 4906 Crenshaw Ave. 21206   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute Cor. P. myocardial infarct<br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) Arteriosclerotic Cor. Ventr. 2 years<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Instantaneous |  |   |  |  |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 76 to 9-11 19 80, that (I) (we) lost<br>saw the deceased alive on 9-11 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Rolando V. Goco, MD   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  | 22c. DATE SIGNED<br>9-12-80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Rolando V. Goco, MD  |  |   |  | 22e. ADDRESS<br>707 E. Fort Ave. Balt. Md  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>9-15-80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.   |  |
| 24 FUNERAL DIRECTOR<br>John C. Miller Inc-6415 Belair Rd.-21206   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 15 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>R. J. McBrady  |  |



London (over)

1-1-1902

1-1-1902

London (over)

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London (over)

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London (over)

London (over)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 0 2 2 0 8 6  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  | REG. NO.   |  |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>GEORGE WOON CHAN  |  |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>SEPTEMBER 29, 1980   |  |   |  |
| 2b HOUR<br>A<br>10:15 M   |  |   |  |  |  |   |  |
| 3 SEX<br>Male   |  | 4 RACE<br>Chinese   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 28, 1886   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>93 YRS.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>China   |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |
| 10 CITY OR TOWN OF DEATH<br>Garrison  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Garrison Valley Nursing Center |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Owner  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Restaurant   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Maryland  |  |   |  | 13b COUNTY<br>Baltimore  |  | 13c CITY OR TOWN<br>Baltimore   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Got Loy Chan   |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lui  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |   |  | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)  |  | 17 INFORMANT Grandson: ADDRESS<br>Fun Wah Chan, 612 Venable Avenue 21218  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>old age = Cardiopulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD = CHF</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>old age</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>years</u><br><u>years</u><br><u>years</u> |  |   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>August 16, 1980</u> to <u>Sept 30, 1980</u> , that <u>(we)</u> saw the deceased alive on <u>Sept (mid) 1980</u> , and that in <u>my</u> opinion death occurred on the date and hour and from the causes stated above, <u>(we)</u> (did) (did not) view the body after death. <u>9/16/80</u>  |  |   |  |  |  |   |  |
| 22b SIGNATURE<br><u>L. Boas</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  | 22c DATE SIGNED<br><u>8/29/80</u>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>L. BOAS MD</u>   |  |   |  | 22e ADDRESS<br><u>50 SCOTT ADAM RD Cockeysville MD 21030</u>   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b DATE<br>10/6/80   |  | 23c NAME OF CEMETERY OR CREMATORY<br>Lorraine Park Cemetery  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn, Balto. Co., MD   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>STEWART & MOWEN CO., 108 W. North Ave. 21201   |  |   |  | 25 DATE REC'D. BY REGISTRAR<br>OCT 1 1980  |  | 25b REGISTRAR'S SIGNATURE<br><u>Infant M. Brady</u>   |  |



STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

80 22087

 FOR  
 STATE  
 REGISTRAR

REG. NO.

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 1. DECEASED NAME<br>FIRST MIDDLE LAST<br><b>CATHERINE R CHAPMAN</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 8 80</b>                                 |  | 2b. HOUR<br>M<br><b></b>  |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>BLACK</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 3 11</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b></b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. COUNTY</b>                         |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>LUTHERVILLE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MEDOWVALE FARM</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b></b>   |   |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>BALTO.</b>   | 13c. CITY OR TOWN<br><b>LUTHERVILLE</b>  | 13d. STREET ADDRESS<br><b>Box 175 SEMINARY AVE LUTHERVILLE</b>                       |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John MASON</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARIE JONES</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>     |   |
| 16b. SOCIAL SECURITY NO.<br><b>213-28-0539</b>  |  | 17. INFORMANT<br><b>NORMAN CHAPMAN LUTHERVILLE MD.</b>   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br><b>410 -</b> |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden Death</b><br><b>2 years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>(1) Diabetes Mellitus (2) Hypertension</b>  |  |  |  |  |   |
| 19a. DATE OF OPERATION<br><b>2 9</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b></b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b></b> |  |  |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b></b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b></b>  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/><br><b></b>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b></b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b></b>                         |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11 3 80</b> , to <b>Present</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>3-3</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |  |  |  |   |
| 22b. SIGNATURE<br><b>J. R. Norris</b>   |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>9-10-80</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. R. NORRIS</b>  |  | 22e. ADDRESS<br><b>3421 Sweet Air Rd, Phoenix, Md, 21131</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>9/12/80</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mem</b>                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cokesville Balto. Md</b>             |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Chapman F/A</b>  |  | ADDRESS<br><b>1701 McCall St</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 11 1980</b>                                  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |  |   |

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 80 22088  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>DOROTHY R. CHILIS   |  |   |  | 2b. HOUR<br>9 1 80 9-50 PM   |  |   |  |
| 3 SEX<br>FEMALE  |  | 4 RACE<br>CAUCASION   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>9 30 27  |  | 6 AGE (IN YEARS LAST BIRTHDAY) 52 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |
| 10 CITY OR TOWN OF DEATH<br>Randallstown   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Balto. County General Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |   |  | 13b. CITY OR TOWN<br>Baltimore   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Peter Rose   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Pauline Karamerou  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  | 16b. SOCIAL SECURITY NO<br>217 26 5220  |  | 17 INFORMANT<br>James Chilis   |  | ADDRESS<br>Same   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardio-pulmonary Arrest</u><br>4151<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Possible Pulmonary Embolism</u><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST<br>(c) <u>Diabetes mellitus</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br>— |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION<br>—  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>—  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>—   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>—   |  |   |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <u>8-25-</u> 19 <u>80</u> to <u>9-1-</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>9-1-</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><u>S. D. Patel</u>   |  |   |  | DEGREE<br>—  |  | 22c. DATE SIGNED<br>9-1-80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. S. D. PATEL M.D.  |  |   |  | 22e. ADDRESS<br>Baltimore County Gen. Hospital   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>9/4/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Greek Orthodox   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn, Md.   |  |
| 24 FUNERAL DIRECTOR<br>Henry W. Jenkins & Sons Company<br>4905 York Road Balto., Md. 21212   |  |   |  | DATE REC'D. BY REGISTRAR<br>SEP 4 1980   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Henry W. Jenkins</u>   |  |

BP

Burial  
Harry W. Jenkins & Sons Company  
4505 York Road, Balto., Md. 21212

Woodlawn

Grass (rhodox)

No 217 25 2220 James Orlis

Peter Forest Pauline

Maryland Baltimore 4508 Underwood Road

Baltimore County General Hospital

U.S. Baltimore County

U.S. Baltimore County

U.S. Baltimore County

U.S. Baltimore County

U.S. Baltimore County

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 0 8 9

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James Vincent CHIDO                              |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>September 4, 1980  |  | 2b. HOUR<br>8:00am                         |
| 3 SEX<br>Male   | 4 RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 5, 1911  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W. Virginia                                | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Welder                      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |   |   |   |  |  |
| 13a. STATE<br>Maryland  | 13b. COUNTY<br>Harford  | 13c. CITY OR TOWN<br>Bel Air  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank -- Chido                                |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Carmela -- DeMasi  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no              |   | 16b. SOCIAL SECURITY NO.<br>213-07-4144   |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Anna C. Chido, Bel Air, Md. |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Intractable Metabolic Acidosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypoxemia, Renal failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Adenocarcinoma of lung</u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

|  |  |  |   |
|--|--|--|---|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>September 2</u> , 19 <u>80</u> , to <u>September 4</u> , 19 <u>80</u> , that (X) (we) last saw the deceased alive on <u>September 4</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (do not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br>Sheldon Milner, M.D.   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br>9/4/80  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Sheldon Milner, M.D.  |  | 22e. ADDRESS<br>9000 Franklin Square Dr. Balto., Md. 21237   |   |

|  |                            |  |   |
|--|----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial               | 23b. DATE<br>Sept. 6, 1980 | 23c. NAME OF CEMETERY OR CREMATORY<br>Bel Air Mem. Gardens | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Bel Air Harford Md. |
| 24. FUNERAL DIRECTOR<br>NAME<br>Howard K. McComas III, Abingdon, Md. |                            | 25a. DATE REC'D. BY REGISTRAR<br>SEP 8 1980                |   |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR 415 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

8 0 2 2 0 9 0

1. FOR  
STATE  
REGISTRAR

|   |  |                  |                  |   |  |                  |   |   |   |                               |                  |   |                                |   |            |   |  |   |          |  |              |              |  |                               |  |  |
|---|--|------------------|------------------|---|--|------------------|---|---|---|-------------------------------|------------------|---|--------------------------------|---|------------|---|--|---|----------|--|--------------|--------------|--|-------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |                  | FIRST<br>CLIFTON |   |  | MIDDLE<br>E.LIAS |   |   | LAST<br>CHISOLM                         |                               |                  | 2a. DATE KNOWN<br>OF DEATH<br>ESTI-<br>MATED  |                                |   | MONTH<br>9 |   |  | DAY<br>30                                       |          |  | YEAR<br>1980 |              |  | 2b. HOUR<br>M<br>10:05<br>p M |  |  |
| 3. SEX<br>male  |  | 4. RACE<br>white |                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Mar. 22, 1915   |  |                  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>65 YRS. |   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN |                               | IF UNDER 24 HRS. |   | 7c. DATE<br>PRONOUNCED<br>DEAD |   |            | MONTH<br>10                                   |  |   | DAY<br>1 |  |              | YEAR<br>1980 |  |                               |  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Maryland  |  |                  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |                  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |                               |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |                                |   |            |   |  |   |          |  |              |              |  |                               |  |  |
| 10. CITY OR TOWN OF DEATH<br>Rosedale   |  |                  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>8226 Old Philadelphia Rd. |  |                  |   |   |   |                               |                  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>Worker                      |                                |   |            | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br>Steel |  |   |          |  |              |              |  |                               |  |  |
| 13a. STATE<br>Maryland  |  |                  |                  | 13b. COUNTY<br>Baltimore  |  |                  |   | 13c. CITY OR TOWN<br>White Marsh  |   |                               |                  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                | 13e. STREET ADDRESS<br>11300 Bird River Grove Rd                                    |            |   |  |   |          |  |              |              |  |                               |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John D. Chisholm  |  |                  |                  |   |  |                  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary -- Knight   |   |                               |                  |   |                                |   |            |   |  |   |          |  |              |              |  |                               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no   |  |                  |                  | (IF YES, GIVE WAR OR DATES)   |  |                  |   | 16b. SOCIAL SECURITY NO.<br>218-07-8019   |   |                               |                  | 17. INFORMANT<br>ADDRESS<br>W. Douglas Smallwood, White Marsh, Md.                              |                                |   |            |   |  |   |          |  |              |              |  |                               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease &<br>4292 CHRONIC obstructive pulmonary disease<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |                  |                  |   |  |                  |   |   |   |                               |                  |   |                                |   |            |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |          |  |              |              |  |                               |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                  |                  |   |  |                  |   |   |   |                               |                  |   |                                |   |            |   |  |   |          |  |              |              |  |                               |  |  |
| 19a. DATE OF OPERATION  |  |                  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |                  |   |   |   |                               |                  |   |                                | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |            |   |  |   |          |  |              |              |  |                               |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |                  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |                               |                  |   |                                |   |            |   |  |   |          |  |              |              |  |                               |  |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                  |                  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)  |  |                  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |                               |                  |   |                                |   |            |   |  |   |          |  |              |              |  |                               |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |                  |   |  |                  |   |   |   |                               |                  |   |                                |   |            |   |  |   |          |  |              |              |  |                               |  |  |
| ACTUAL<br>SIGNATURE<br>Ann M. Dixon   |  |                  |                  | M.D. Assistant  |  |                  |   | MEDICAL EXAMINER  |   |                               |                  | DATE<br>SIGNED 10-2-80  |                                |   |            |   |  |   |          |  |              |              |  |                               |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Ann M. Dixon, M.D.  |  |                  |                  | ADDRESS<br>111 Penn St.   |  |                  |   |   |   |                               |                  |   |                                |   |            |   |  |   |          |  |              |              |  |                               |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |                  |                  | 23b. DATE<br>Oct. 4, 1980   |  |                  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Fork U. Methodist Cem.  |   |                               |                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Fork Balto Md.                                    |                                |   |            |   |  |   |          |  |              |              |  |                               |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Howard K. McComas   |  |                  |                  |   |  |                  |   |   |   | ADDRESS<br>111, Abingdon, Md. |                  |   |                                | 25a. DATE REC'D. BY REGISTRAR<br>OCT 6 1980   |            |   |  | 25b. REGISTRAR'S SIGNATURE<br>Dixey McCreedy    |          |  |              |              |  |                               |  |  |

MEDICAL CERTIFICATION



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 0 9 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Ethel E. Clements</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>September 27 1980</b>           |   |  | 2b. HOUR<br><b>1:51 P M</b>   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 6, 1898</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br>IF UNDER 24 HRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Josephs Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Granite</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>Davis Ave. B8 21163</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John McDonald</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emme Henry</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>214-74-4907</b>  |  | 17. INFORMANT<br><b>Pasadena, Maryland</b><br><b>Joseph G. Hickey 7885 Belhaven Ave. 21122</b>  |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>4414</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Abdominal Aortic Aneurysm.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>9/26/80</b>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/16</b> 19 <b>80</b> to <b>9/27</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>9/27</b> 19 <b>80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                 |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Lu O'Neil</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>9/27/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ERLANDO ROMERO</b>   |  |  |  | 22e. ADDRESS<br><b>ST. Joseph Hosp.</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>9/30/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Good Shepherd Cemetery</b>            |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Ellicott City Howard Md</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Loring Byers Funeral Directors, P.A. 21133</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 30 1980</b>                            |   | 25b. REGISTRAR'S SIGNATURE<br><b>Loring Byers</b>                            |  |  |

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

UNITED STATES OF AMERICA



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IN EXECUTING THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

| Items #18a-22a Film G548 10/27/80 STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |  |  |  |                 |   |  |   |  | REG. NO. 8 0 2 2 0 9 2 |  |
|---|-------------------------|--|--|--|-----------------|---|--|---|--|------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FRANCINE G. COHEN</b>  |                         |  |  |  |                 | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 9 10 19 80             |  | 2b. HOUR<br>M   |  |                        |  |
| 3. SEX<br><b>female</b>   | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 21, 1946</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>34</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN  | IF UNDER 24 HRS | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>9 11 19 80</b>                                 |  | 2d. HOUR<br><b>5p</b> M                                 |  |                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD                              |  |   |  |                        |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Meushaw's Motor Inn, Whitestone Ct.</b> |  |  |                 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Registered Nurse</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>V.A. Hosp.</b>  |  |                        |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                         |  |  |  |                 |   |  |   |  |                        |  |
| 13a. STATE<br><b>D.C.</b>   |                         | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Washington</b>   |                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2939 Van Ness Street N.W.</b> |  |                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jack Cohen</b>   |                         |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lillian Weissblatt</b>   |                 |   |  |   |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>084-36-8832</b>   |  | 17. INFORMANT ADDRESS<br><b>Potomac, Md.</b>   |                 |   |  |   |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute drug intoxication</b><br><b>9500</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |  |  |  |                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |                         |  |  |  |                 |   |  |   |  |                        |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |                 | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |   |  |                        |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>9/10/80</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Ingested drugs</b>   |                 |   |  |   |  |                        |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>bldg.</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN<br><b>Meushaw's Motor Inn Whitestone Ct.</b>  |                 | COUNTY STATE<br><b>Balto. Co., Md.</b>  |  |   |  |                        |  |
| 22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |                         |  |  |  |                 |   |  |   |  |                        |  |
| ACTUAL SIGNATURE<br><i>[Signature]</i>  |                         | TITLE (SPECIFY)<br><b>Assistant</b> MEDICAL EXAMINER   |  |  |                 | DATE SIGNED <b>9-12-80</b>  |  |   |  |                        |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>  |                         | ADDRESS<br><b>111 Penn St.</b>   |  |  |                 |   |  |   |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>9-14-1 980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Judean Memorial Gardens</b>   |                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Olney, Montgomery, Maryland</b>                |  |   |  |                        |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Danzansky-Goldberg Chapels</b>  |                         | ADDRESS<br><b>1170 Rockville Pike; Rockville, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 1, 1980</b>  |                 | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |                        |  |

(M)

00-21-2

000 132



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advice.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 0 2 2 0 9 3  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>BESSIE COLEMAN</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>9-22-80</b>  |  | 2b. HOUR <b>2 55 P M</b>  |  |
| 3. SEX <b>FEMALE</b>   |  | 4. RACE <b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>4 14 19 61</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>BALTIMORE COUNTY GEN. HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALESPERSON</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>HECHT CO.</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MARYLAND</b>   |  | 13b. CITY OR TOWN <b>BALTIMORE</b>  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS <b>310 S. PULASKI ST. #21223</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>BENJAMIN COLEMAN</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FANNIE BLOCK</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO   |  | 17. INFORMANT <b>MR. HARRY COLEMAN</b><br><b>6800 LIBERTY RD., APT. 716 #21207</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of ovary with ascites and metastasis</b><br>1830<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                           |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-22-80</b> to <b>9-22-80</b> , that (I) (we) lost saw the deceased alive on <b>9-22-80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.   |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Soonchul Hong</b>  |  |   |  | DEGREE   |  | 22c. DATE SIGNED <b>9-22/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SOONCHUL HONG</b>   |  |   |  | 22e. ADDRESS <b>Baltimore County General Hosp.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>SEPT. 23, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>MOSES MONTEFLORE WOODMOOR HERREW BALTO</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>SEP 26 1980</b>   |  |   |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215   |  |   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |   |  |





FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 0 9 4

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>STEPHEN W COLLINS                                |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9 11 80 |   |  | 2b. HOUR<br>5 15 AM  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 12 02  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALT MD                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALT COUNTY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MANOR CARE TOWSON |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Glazer Pittsburg Plate Glass |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |  |  |   |  |  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Balto.  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>STEPHEN ISOLA SIKSKI                          |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>XXXXXXXXXXXXX Mary Kaszak  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO              |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-01-8514   |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Irene A. Collins same  |  |  |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) LYMPHOMA<br>2028<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>5 YRS |  |
|---|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 28, 19 80, to Sept 11, 19 80, that (I) (we) last saw the deceased alive on 10 Sept 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Walter T. Kees MD   |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>11 Sept 1980  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WALTER T. KEES   |  |  |  | 22e. ADDRESS<br>Baltimore Md 21111   |  |   |  |

|   |  |                             |  |   |  |  |  |
|---|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                |  | 23b. DATE<br>Sept. 13, 1980 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Heart of Jesus |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Balto. Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Leonard J. Ruck, Inc. 5305 Harford Road 21214 |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 15 1980                |  | 25b. REGISTRAR'S SIGNATURE<br>Rufus H. H. H.                       |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



SEP 12 1980

*[Handwritten signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 0 9 5

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |                          |   |  |  |   |  |                                |  |                                |  |
|--|--|--------------------------|---|--|--|---|--|--------------------------------|--|--------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>John H. Cooper</u>  |  |                          | 2a. DATE OF DEATH MONTH DAY YEAR <u>9-30-1980</u>   |  |  | 2b. HOUR <u>2:30</u> PM   |  |                                |  |                                |  |
| 3. SEX <u>male</u>   |  | 4. RACE <u>Caucasian</u> |   | 5. DATE OF BIRTH MONTH DAY YEAR <u>4-17-1988</u> |  | 6. AGE (IN YEARS LAST BIRTHDAY) <u>92</u> YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS |  | 8. IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>England</u>   |  |                          | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore County</u> MD. |                                |  |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u>   |  |                          | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Perring Pkwy Nsg Home</u> |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Foreman - Shipyard</u>   |  |                                | 12b. KIND OF BUSINESS OR INDUSTRY                                |                                |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Md.</u> |  |                          | 13b. CITY OR TOWN <u>Balto.</u>   |  |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                                | 13d. STREET ADDRESS <u>8425 Old Harford Rd Apt. E</u>            |                                |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>William Cooper</u>  |  |                          | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Ellen Willisicroft</u>  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>   |  |                                | 16b. SOCIAL SECURITY NO. <u>213-03-5850</u>                      |                                |  |
| 17. INFORMANT ADDRESS <u>Miss Helen Cooper same</u>  |  |                          |   |  |  |   |  |                                |  |                                |  |

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Insufficiency</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| 42922<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>A SCUD</u>  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Renal arteriosclerosis</u> |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a):

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>9/30/80</u> P.M. <u>19</u>        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>416/78</u> |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>9/30/80</u>  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9/30/80</u> to <u>9/30/80</u> , that (I) (we) lost saw the deceased alive on <u>9/30/80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not see the body after death, so state.) |  |   |  |  |  |   |  |
| 22b. SIGNATURE <u>Leonard J. Buck</u>   |  | DEGREE <u>MD</u>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <u>10-1-80</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Leonard J. Buck</u>  |  | 22e. ADDRESS <u>5503 North Rd Balto Md</u>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |  | 23b. DATE <u>Oct. 3, 1980</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Md.</u>  |  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 24. FUNERAL DIRECTOR <u>Leonard J. Buck Inc. Baltimore, Maryland</u> |  | 25a. DATE REC'D. BY REGISTRAR <u>OCT 2 1980</u> |  | 25b. REGISTRAR'S SIGNATURE <u>History</u> |  |
|--|--|---|--|---|--|



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page-3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

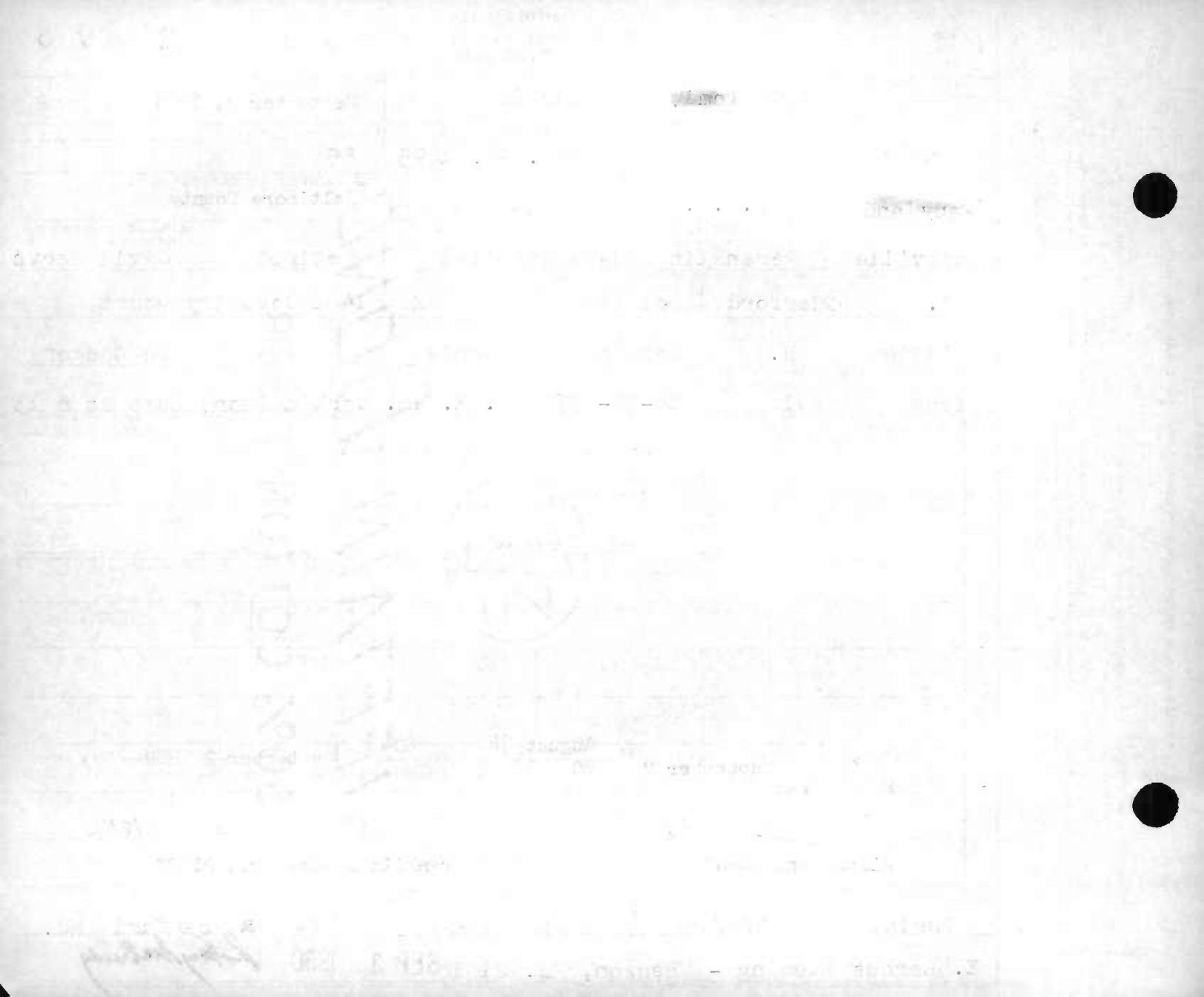
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 0 2 2 0 9 6  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH   |  |  |  | 2b. HOUR   |  |  |  |
| FIRST MIDDLE LAST<br>Elmer (nmi) Corbin  |  |   |  | MONTH DAY YEAR<br>September 2, 1980   |  |  |  | 3:00P M  |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Mar. 28, 1895   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br>85   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                          |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Civil Serv  |  |  |  |
| 13a. STATE<br>Md.  |  |   |  | 13b. COUNTY<br>Harford  |  | 13c. CITY OR TOWN<br>Bel Air   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET ADDRESS<br>1401 Coventry Court   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William H. Corbin  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annie Mc Gregor  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yess   |  | 16b. SOCIAL SECURITY NO.<br>WWI   |  | 17. INFORMANT<br>Mr. E. Wm. Corbin (son) Same As # 13   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br><u>5789</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>GI bleeding</u>  |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August 14, 1980</u> , to <u>September 2, 1980</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>September 2, 1980</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Aiman N. Daghestani</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>9/2/80   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Aiman Daghestani  |  |   |  | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>9/5/1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Bel Air Memorial  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Bel Air Harford Md.                    |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>E. Barnes Fleming - Benson, Md. 21018  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 3 1980   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |  |  |

BP





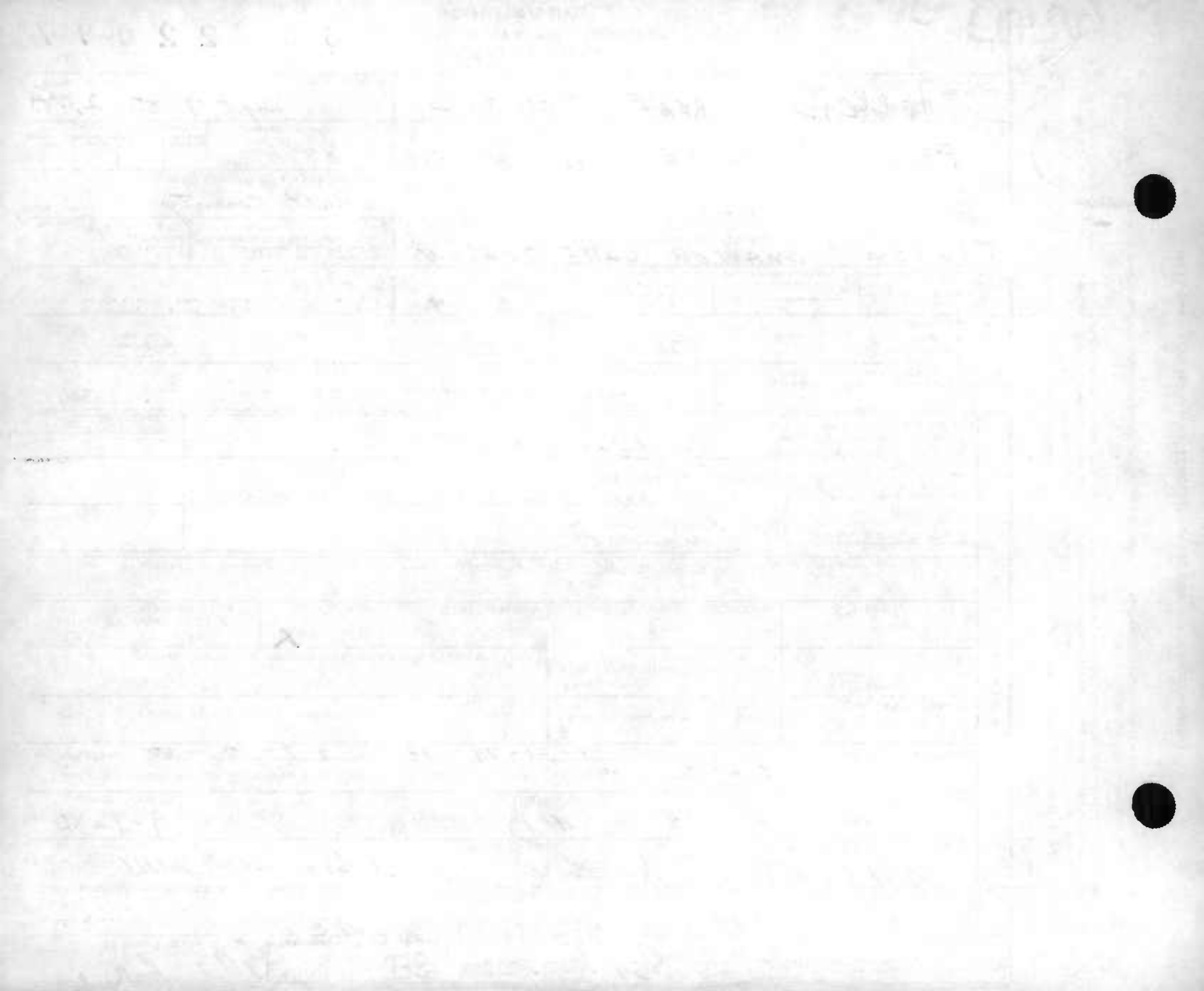
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 80 22097   |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>HELEN IRENE Cowan</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>Sept 7 80</b>  |  |   |  |
| 3 SEX <b>FEMALE</b>  |  |   |  | 2b. HOUR <b>2:05 PM</b>  |  |   |  |
| 4 RACE <b>WHITE</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR <b>11 25 1890</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>CANADA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balt. County</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MAVER CARE TOWSON</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RESEARCH WORKER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>AUTHOR</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MARYLAND</b> 13c. COUNTY <b>BALTIMORE</b>   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM COWAN</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MINNIE JUSTIN</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO. <b>215.30.1711</b>   |  | 17. INFORMANT ADDRESS <b>PEARL BLOOD KENNETH SQUARE, PA. 19348</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4370</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral artery sclerosis Vascular</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <b>disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>disease</b> |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-21-74</b> , 19 <b>74</b> , to <b>9-7-80</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>9-6-80</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Walter T. Kees</b> DEGREE <b>MD</b>  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <b>9-7-80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WALTER T. KEES</b>  |  |   |  | 22e. ADDRESS <b>Monkton Md 21111</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>   |  | 23b. DATE <b>9/8/1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>GREEN MOUNT CREMATORY</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS <b>WALTER BROOKS BRADLEY, INC., BALTO., MD. 21222</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>SEP 15 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Patricia K. B...</b>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 0 2 2 0 9 8   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Helen C. COX</i>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <i>9 23 80</i>   |  | 2b. HOUR <i>9:05</i> M.   |  |
| 3. SEX <i>Female</i>  |  | 4. RACE <i>white</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <i>July 19, 1906</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County, MD.</i>   |  |
| 10. CITY OR TOWN OF DEATH <i>Randallstown</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Bath Co. Gen. Hosp.</i>   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Accountant</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>Account Firm</i>   |  |
| 13a. STATE <i>Maryland</i>  |  | 13b. COUNTY <i>Baltimore</i>  |  | 13c. CITY OR TOWN <i>Woodlawn</i>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Donald Clarke</i>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elsie M. Smith</i>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>   |  | 16b. SOCIAL SECURITY NO. <i>21512-9676</i>  |  |
| 17. INFORMANT ADDRESS <i>Donald Cox</i>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i><br>436-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Congestive Heart Failure Atherosclerotic Cardiovascular disease</i> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10-17</i> , 19 <i>77</i> , to <i>9-23</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>9-23</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (do not) view the body after death. |  |   |  | 22b. SIGNATURE <i>[Signature]</i> DEGREE <i>MD</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <i>9/23/80</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>D.N. DAS</i>   |  | 22e. ADDRESS <i>5412 Old Court Rd.</i>  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>   |  | 23b. DATE <i>9/26/80</i>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Woodlawn Baltimore Md.</i>   |  | 24. FUNERAL DIRECTOR NAME <i>[Signature]</i> ADDRESS <i>[Signature]</i>   |  | 25a. BY RECEIVED BY <i>[Signature]</i> 25b. RECEIVED BY <i>[Signature]</i>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  | 8022099                      |  |
|---|--|--|--|---|--|---|--|---|--|------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |   |  |   |  |   |  |                              |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>GRACE   |  | MIDDLE<br>S.  |  | LAST<br>COZZONE   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9 - 1 - 80   |  | 2b. HOUR<br>10P M            |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 3 03  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |  |   |  |                              |  |
| 10. CITY OR TOWN OF DEATH<br>CATONSVILLE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SHANGRI-LA NURSING HOME |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER                   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>---   |  |                              |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |   |  |   |  |                              |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>WOODLAWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>6727 1/2 WINDSOR MILL ROAD   |  |                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CHARLES B. SMITH  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>EDNA B. HAWKINS  |  |   |  |   |  |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>---   |  | 17. INFORMANT<br>ADDRESS<br>VIRGINIA MICHEL 6727 1/2 WINDSOR MILL ROAD                          |  |   |  |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ASCVD<br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) S/P cerebral aneurysm<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>chronic heart failure<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>years |  |  |  |   |  |   |  |   |  |                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br>UTI   |  |  |  |   |  |   |  |   |  |                              |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |   |  |                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 19 79, to Sept 1 19 80, that (I) (we) lost<br>saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                          |  |  |  |   |  |   |  |   |  |                              |  |
| 22b. SIGNATURE<br>M S P L M D   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br>9/2/80  |  |                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>M Peksa  |  | 22e. ADDRESS<br>7098 Macbeth Way 21284   |  |   |  |   |  |   |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>9/4/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>LOUDON PARK CEMETERY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD.                                     |  |   |  |                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 5 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>R. J. McCarty   |  |                              |  |

2nd

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 1 0 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |  |   |  |  |  |
|---|--|---|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CHARLES J. CRAFTON</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09 07 80</b>                 |   |  | 2b. HOUR<br><b>A M</b>   |   |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>03 19 96</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>WESTVIEW PARK</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>906 SEDGELEY ROAD</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TAVERN OWNER</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SELF-EMPLOYED</b>  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>MARYLAND</b>  |  |   | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>WESTVIEW PARK</b>                                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>906 SEDGLEY ROAD 21228</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ELSWORTH CRAFTON</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MAMIE MANION</b>   |   |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>217-05-7843</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>ROSE E. CRAFTON 906 SEDGLEY ROAD</b>            |  |   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive Coronary Infarction</b><br><b>2500</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>arteriosclerosis heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Dilated Myocardium</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>15 yr</b><br><b>5 yr</b> |  |   |  |   |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>march</b> , 19 <b>55</b> , to <b>Sept 4</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>July 26</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>M. W. JACOBSON M.D.</b>  |  |   | DEGREE   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>9-8-80</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. W. JACOBSON, M.D.</b>  |  |   | 22e. ADDRESS<br><b>6810 PARK HEIGHTS AVENUE</b>                        |   |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |   | 23b. DATE<br><b>09-10-80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>                    |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>   |  |   | ADDRESS<br><b>21229 4107 WILKENS AVE.</b>                              |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 9 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>P. J. H. H. H.</b>  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

|   |  |  |  |  |  |   |   |   |   |  |
|---|--|--|--|--|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARIE A. CRANDALL</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 12 80</b>  |  |  | 2b. HOUR<br><b>10:00A</b>   |   |   |   |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Mar. 17, 1910</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b>   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS</b>   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, D.C. U.S.A.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                    |   |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Baltimore Medical Center</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retail Sales</b>  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>21239</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>5730 Fenwick Avenue</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William H. Mullen</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lillian Morrow</b>   |  |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>----</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Bertram H. Crandall Miami Lakes, Fla.</b>   |  |   |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary hemorrhages</b><br><b>2089</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Acute myelofibrosis (leukemia) with thrombo-cytopenia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>-----</b>                                  |  |  |  |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>S/P Carcinoma of ovary</b>  |  |  |  |  |  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |   |   |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8/29</b> , 19 <b>80</b> , to <b>9/12</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>9/12</b> , 19 <b>80</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |  |  |  |   |   |   |   |  |
| 22b. SIGNATURE<br><i>Rudiger Breiteneker</i>  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>9/12/80</b>  |   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Rudiger Breiteneker, M.D.</b>   |  |  | 22e. ADDRESS<br><b>6701 N. Charles St. Towson, Md. 21204</b>   |  |  |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  |  | 23b. DATE<br><b>Sept. 13, 80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Cemetery Baltimore, Md.</b> |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William E. Johnson</b>   |  |  | ADDRESS<br><b>8521 Loch Raven Blvd.</b>  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 15 1980</b>                                   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Rudiger Breiteneker</i>  |   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|---|--|---|--|
| 1- FOR STATE REGISTRAR  |  | REG. NO.  |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br><b>HARRY CURTIS CRANSTON</b>   |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>SEPT. 11, 1980</b>  |  |
| 3 SEX<br><b>Male</b>  |  | 2b HOUR P<br><b>6:10 M</b>  |  |
| 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>July 27, 1906</b>  |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS   |  | 7 IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>  |  |
| 10 CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSPI:TAL</b>             |  |
| 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales Engineer</b>   |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |
| 13a STATE<br><b>Maryland</b>  |  | 13b COUNTY<br><b>Baltimore</b>  |  |
| 13c CITY OR TOWN<br><b>Towson</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 13e STREET ADDRESS<br><b>305 E. Joppa Rd.</b>   |  | 14 FATHER'S NAME FIRST MIDDLE LAST  |  |
| 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |
| 16b SOCIAL SECURITY NO.<br><b>184-01-2936</b>   |  | 17. INFORMANT ADDRESS<br><b>Harry J. Cranston, Jr. Fallston, Md.</b>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF<br><b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>SEVERE CONGESTIVE HEART FAILURE</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>SEPT. 11, 1980</b> , to <b>SEPT 11, 1980</b> , that <b>XX</b> saw the deceased alive on <b>SEPT. 11, 1980</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not view the body after death.   |  |   |  |
| 22b. SIGNATURE<br><i>Beatriz P. Dizon</i>   |  | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22c. DATE SIGNED<br><b>Sept. 11, 1980</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BEATRIZ P. DIZON, M.D.</b>  |  |
| 22e. ADDRESS<br><b>7620 YORK RD. 21204</b>  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |
| 23b. DATE<br><b>Sept. 15, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mem. Cockskeysville, Balto., Md.</b>  |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE   |  | 24. FUNERAL DIRECTOR NAME<br><b>Mitchell-Wiedefeld Home, Inc. Balto., Md.</b>   |  |
| 24. ADDRESS<br><b>6500 York Rd.</b>   |  | 25. DATE RECEIVED BY REGULAR AR 25<br><b>SEP 17 1980</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

Items 19a & 19b G550 12/15/80 da STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Grace VICTORIA CRISTELLO</b> |  |  | 2r. DATE OF DEATH MONTH DAY YEAR<br><b>September 28 1980</b> |  |  | 2b. HOUR<br><b>7:40 a.m.</b>   |  |   |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>WHITE</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10/6/1920</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>59 yrs.</b> YRS                                 |  | 7 UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b> |  |
| 7r. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>Baltimore County</b> MD.            |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>ROSSVILLE</b>                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SQUARE HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY           |  |

|   |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTO.</b>                   |  | 13c. CITY OR TOWN<br><b>DUNDALK</b>                                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>29 EASTSHIP RD. 21222</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>RALPH MARINO</b>                      |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JENNY METALLO</b> |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |  | 16b. SOCIAL SECURITY NO.<br><b>213.18.6797</b> |  | 17 INFORMANT ADDRESS<br><b>NICK COSTELLO (HUSBAND) SAME AS 13e</b>    |  |   |  |   |  |

|   |  |   |  |
|---|--|---|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br><b>8880</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrest; Massive Pulmonary Emboli</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Status Post Hip Surgery</b>                    |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

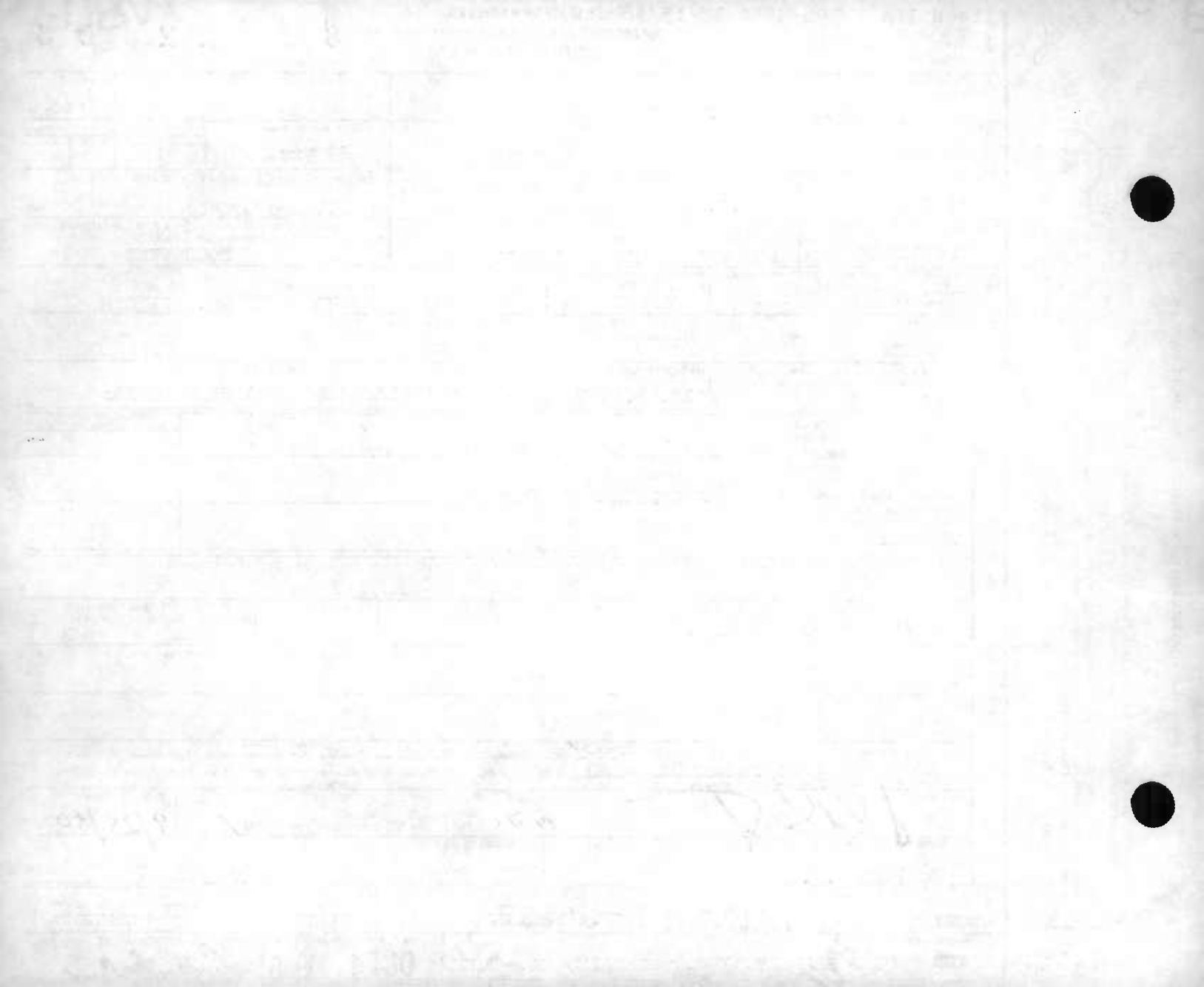
|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION<br><b>/15/80</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Unstable intertrochanteric fracture</b> |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21r. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21r. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |

|  |  |   |  |                                    |  |
|--|--|---|--|------------------------------------|--|
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 12 19 80</b> to <b>September 28 19 80</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>September 28 19 80</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. |  |   |  |                                    |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  | DEGREE<br><b>M.D.</b>                                   |  | 22c. DATE SIGNED<br><b>9/28/80</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Benitez M.D.</b>   |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive 21237</b> |  |                                    |  |

|  |  |                               |  |  |  |   |  |
|--|--|-------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b> |  | 23b. DATE<br><b>10/1/1980</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. STANISLAUS CEM.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b> |  |
|--|--|-------------------------------|--|--|--|---|--|

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>WALTER BROOKS BRADLEY, INC., DUNDALK, MD. 21222</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 1 1980</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |  |
|---|--|--|--|--|--|







TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

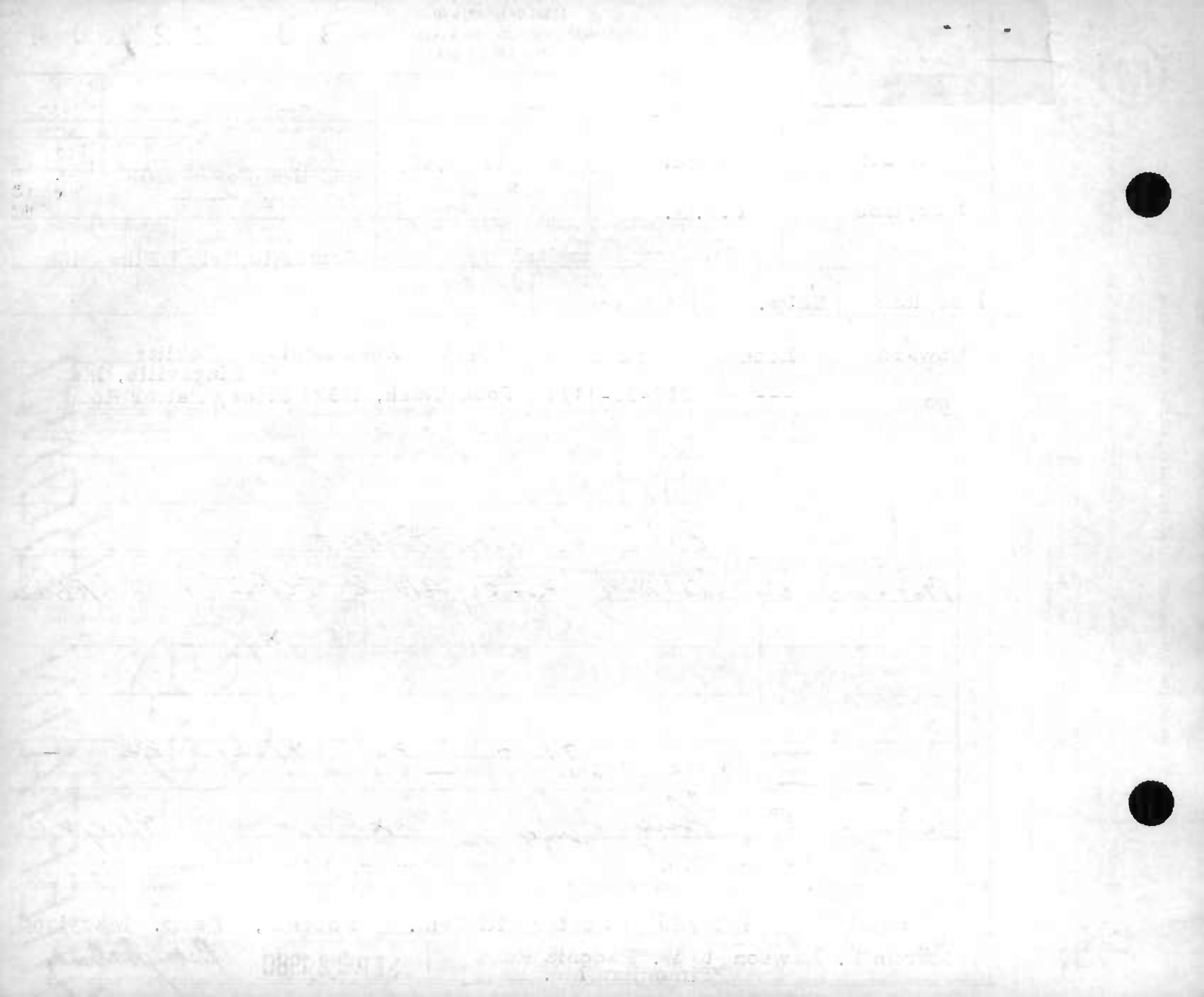
DHMH: 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8022104

REG. NO.

|  |  |  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  |  | 2a. DATE OF DEATH  |  |  | MONTH DAY YEAR  |  |  | 2b. HOUR  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)  |  |  | FIRST MIDDLE LAST  |  |  | Sept. 18, 1980  |  |  | 10:47am   |  |  |
| 3 SEX  |  |  | 4 RACE   |  |  | 5. DATE OF BIRTH  |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  |  |
| Female   |  |  | Cauc.  |  |  | 4 10 1940   |  |  | 40 YRS  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b CITIZEN OF WHAT COUNTRY?  |  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |  |
| Maryland   |  |  | U.S.A.   |  |  |   |  |  | Baltimore County MD.  |  |  |
| 10 CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |
| Towson   |  |  | St. Joseph hospital  |  |  | Domestic Help   |  |  | Elks Club   |  |  |
| 13a STATE  |  |  | 13b COUNTY   |  |  | 13c CITY OR TOWN  |  |  | 13d INSIDE CITY LIMITS?   |  |  |
| Maryland   |  |  | Balto.   |  |  | Towson  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14 FATHER'S NAME   |  |  | 15 MOTHER'S MAIDEN NAME  |  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 16b SOCIAL SECURITY NO.   |  |  |
| Howard Leon Nash   |  |  | Sophie Anna Louise Boblitz   |  |  | no  |  |  | 219-36-1119   |  |  |
| 17 INFORMANT   |  |  | ADDRESS  |  |  | 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |
| John Nash, 12321 Stoney Batter Road  |  |  | Kingsville, Md   |  |  | Severe Metabolic Acidosis   |  |  |   |  |  |
|  |  |  |  |  |  | IMMEDIATE CAUSE (a) Severe Metabolic Acidosis   |  |  |   |  |  |
|  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |  |
|  |  |  |  |  |  | (b) Shock   |  |  |   |  |  |
|  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |  |
|  |  |  |  |  |  | (c) Cardio Respiratory Arrest   |  |  |   |  |  |
|  |  |  |  |  |  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):                   |  |  |   |  |  |
|  |  |  |  |  |  | Metabolic Encephalopathy Secondary to Acute and Chronic Alcohol Abuse   |  |  |   |  |  |
|  |  |  |  |  |  | Metabolic Encephalopathy Secondary to Acute and Chronic Alcohol Abuse   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |
|  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  |  | 21b. TIME OF INJURY  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |   |  |  |
|  |  |  | HOUR A.M. MONTH DAY YEAR   |  |  |   |  |  |   |  |  |
|  |  |  | P.M. 19  |  |  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION   |  |  |   |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  |  | STREET  |  |  | CITY OR TOWN COUNTY STATE   |  |  |
|  |  |  |  |  |  |   |  |  |   |  |  |
| 22a. I certify that (I) this hospital attended the deceased from 9/6, 1980, to 9/12, 1980, that (I) lost   |  |  | 22b. SIGNATURE   |  |  | DEGREE  |  |  | 22c. DATE SIGNED  |  |  |
| saw the deceased alive on 9/12, 1980, and that in (my) opinion death occurred on the date and hour and from the causes stated                      |  |  | George E. LaRocco, M.D.  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  |  | 9/15/80   |  |  |
| above, (I) (did) (did not) view the body after death.  |  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e. ADDRESS  |  |  |   |  |  |
|  |  |  | George E. LaRocco, M.D.  |  |  | 7600 Osler Dr. Suite 311 Towson, Md. 21204  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION   |  |  |
| Burial   |  |  | 9/21/80  |  |  | Poplar Hill Cem.  |  |  | CITY OR TOWN COUNTY STATE   |  |  |
|  |  |  |  |  |  |   |  |  | Phoenix, Balto, Maryland  |  |  |
| 24. FUNERAL DIRECTOR   |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |   |  |  |
| Martin D. Lawson   |  |  | 10 W. Padonia Rd Timonium Md.  |  |  | SEP 22 1980   |  |  | P. J. McQuade   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |  |   |  |  |  | 8 0 2 2 1 0 5  |  |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. STATE REGISTRAR   |  |  |  |   |  |   |  |  |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>DOROTHY CUSTER</b>  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>SEPTEMBER 27, 1980</b>  |   |  |  |  | 2b. HOUR<br><b>10 A.M.</b>                                   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>DECEMBER 14, 1920</b>   |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.                                  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.            |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE, MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY, MD.</b>               |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>EASTWOOD</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>7015 GOUGH ST. # 21224.</b> |  |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSE WORK</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME.</b> |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> 13b. CITY OR TOWN <b>BALTIMORE</b> 13c. CITY OR TOWN <b>EASTWOOD</b>   |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET ADDRESS<br><b>7015 GOUGH ST. BALTO CO., MD.</b>                        |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JOSEPH ISZKIEWICZ</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>CATHERINE JURAS</b>   |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217-05-6604</b>   |  | 17. INFORMANT<br><b>LERROY W. CUSTER ;</b>  |  |   | ADDRESS<br><b>7015 GOUGH ST. BALTO., 21224, MD.</b>                                |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1749</b> IMMEDIATE CAUSE (a) <b>Carcinoma of the breast</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 yrs</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/28</b> , 19 <b>—</b> , to <b>9/16</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>9/16</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Arthur A. Serpick</b>   |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>9/29/80</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ARTHUR A. SERPICK</b>  |  |  |  |   | 22e. ADDRESS<br><b>302 Green Spring Station, Lutherville<br/>1114 ST. PAUL ST., BALTO., MD.</b>  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>9-30-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. STANISLAUS CEM.</b>  |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>6515 BOSTON AVE., BALTO., MD.</b>    |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Charles S. Siefert &amp; Son, Inc.</b>   |  |  |  |   | ADDRESS<br><b>6224 EASTERN AVE. BALTO., 21224, MD.</b>   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 29 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>L. J. H. H. H.</b>          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 0 2 2 1 0 6   |                     |  |  |
|---|--|---|--|---|---------------------|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |                     |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MYRTLE C. DAMEWOOD   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>08 28 80 |   | 2b. HOUR<br>10:00 P |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>9 23 94  |                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>TOWSON - Balto. County MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GBMC 6701 N. CHARLES STREET |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Domestic Work  |                     | 12b. KIND OF BUSINESS OR INDUSTRY<br>Private homes   |  |
| 13a. STATE<br>Md.   |  |   |  | 13b. COUNTY<br>Baltimore  |                     | 13c. CITY OR TOWN<br>Baltimore   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>B. W. Carper   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Gertrude Britts   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |                     |  |  |
| 16b. SOCIAL SECURITY NO.<br>212-34-2879   |  | 17. INFORMANT ADDRESS<br>5800 Halwyn Ave.   |  |   |                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>PREVIOUS M.I.'S</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |   |  |   |                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |  |   |                     |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                     |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |                     |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>08/15</u> , 19 <u>80</u> , to <u>08/28</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>08/28</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |                     |  |  |
| 22b. SIGNATURE <u>[Signature]</u> DEGREE  |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |                     | 22c. DATE SIGNED<br>08/28/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. E. YRIGOYEN  |  |   |  | 22e. ADDRESS<br>GREATER BALTIMORE MEDICAL CENTER  |                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal  |  | 23b. DATE<br>8/29/80  |  | 23c. NAME OF CEMETERY OR CREMATORY  |                     | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR NAME<br>Anatomy Board  |  |   |  | ADDRESS<br>Balto., Md.  |                     | 25a. DATE REC'D. BY REGISTRAR<br>SEP 9 1980  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |                     |  |  |

REVISED 10/1/1979

377



Item 18b G548 10/14/80 dad

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 22107

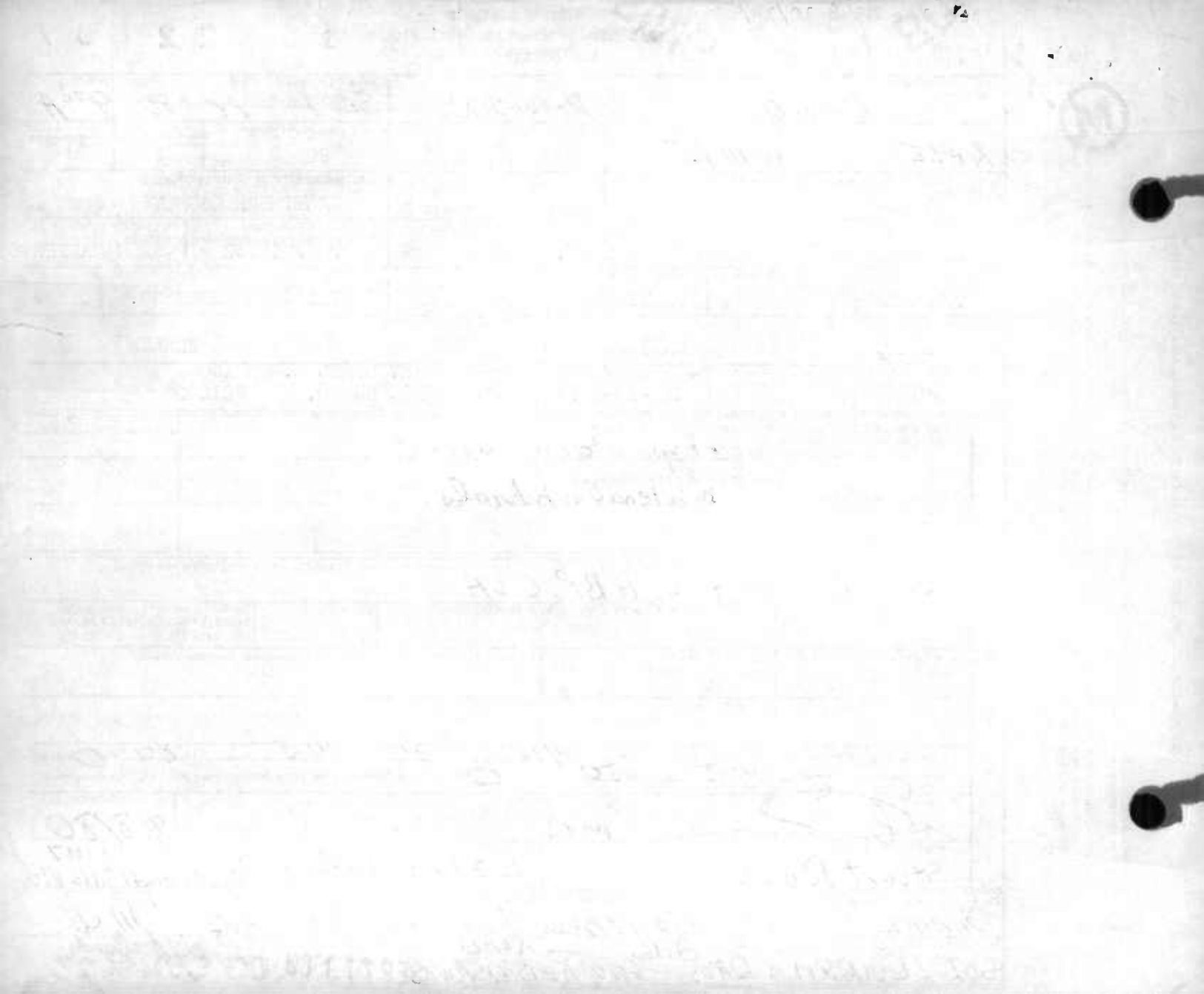
REG. NO.

|   |  |   |  |  |  |  |  |                                  |
|---|--|---|--|--|--|--|--|----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>DAVID DAVISON</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPT 18 80</b>   |  |  | 2b. HOUR<br><b>9:25 A.M.</b>                                 |  |                                  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JUNE 10, 1898</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.                              |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                            |  | 8. IF UNDER 24 HRS<br>HOURS MIN. |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |   | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                 |  |  |                                  |
| 12. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>RANDALLSTOWN CONV. CENTER</b> |  |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PROPRIETOR</b> |  | 15. KIND OF BUSINESS OR INDUSTRY<br><b>SNOW MASTER CO.</b>   |                                  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  |   | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |                                  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ISAAC DAVISON</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>IDA BERLOW</b>   |  |  |  |  |                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220-14-3573</b>   |  | 17. INFORMANT <b>MRS. ETHEL DAVISON</b><br><b>2319 SUGAR CONE RD. #21209</b>   |  |  |  |                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>respiratory arrest</b><br>8520<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>bilateral subdural Hematoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>Diabetes mellitus, HBP, CVA</b> |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                                  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |                                  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |                                  |
| 22a. I certify that (1) this hospital attended the deceased from <b>9/16</b> , 19 <b>80</b> , to <b>9/18</b> , 19 <b>80</b> , that (1) (we) lost saw the deceased alive on <b>9/18</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |  |                                  |
| 22b. SIGNATURE<br><b>Stuart Ross</b> M.D.<br>DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |  |  |  |  | 22c. DATE SIGNED<br><b>9/18/80</b>   |                                  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Stuart Ross</b>   |  |   |  | 22e. ADDRESS<br><b>10219 S. Rutledge Rd, Owings Mills MD 21117</b>             |  |  |  |                                  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>SEPT 19/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HEBREW FRIENDSHIP</b>                 |  | 23d. LOCATION<br>OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b> |  |                                  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL. LEVINSON &amp; BROS</b>   |  |   |  | 25a. DATE REC'D BY REGISTRAR<br><b>SEP 23 1980</b>                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>             |  |                                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

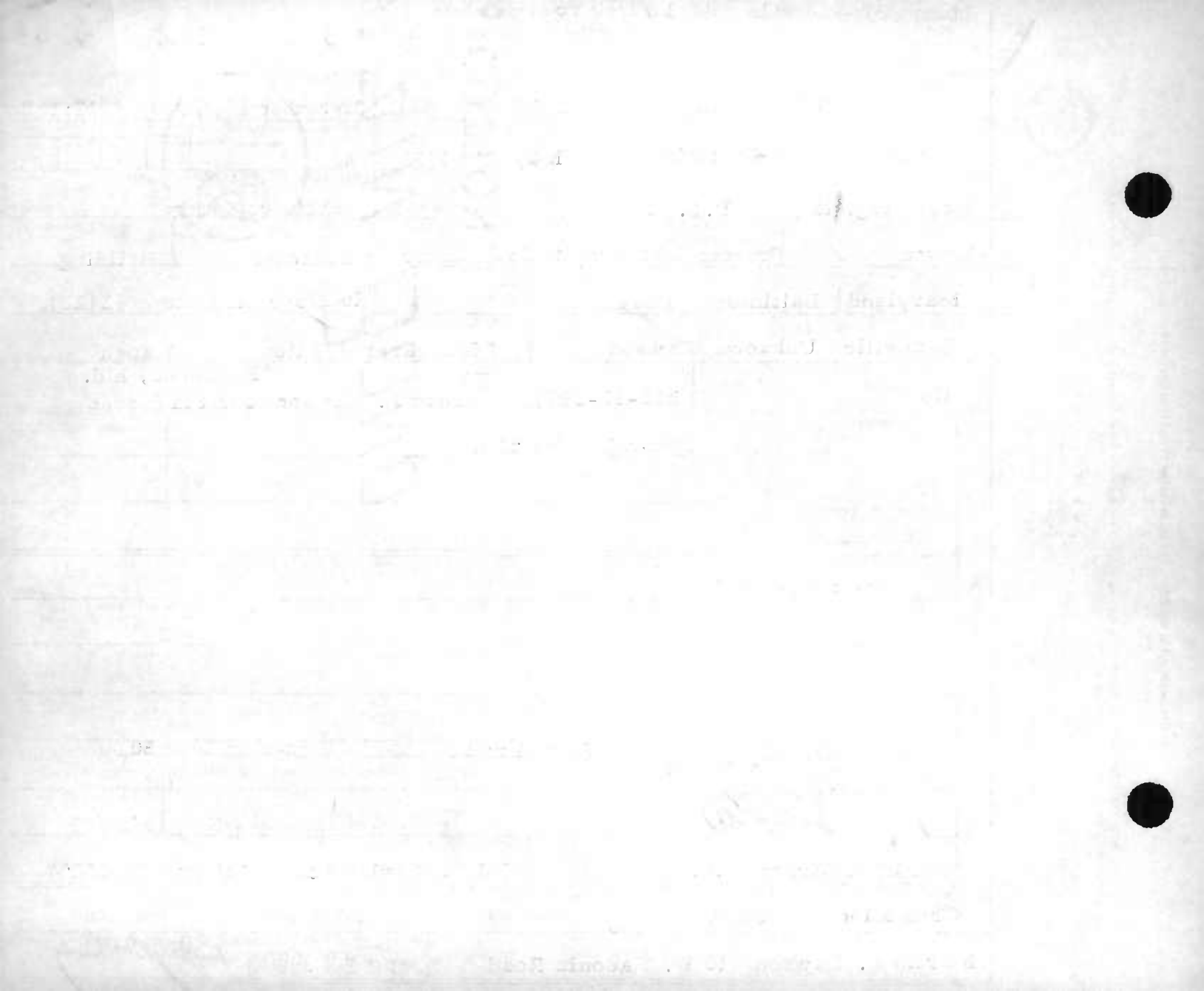


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |                          |  |  |   |                  | 8 0 2 2 1 0 8   |  |
|---|--|--|--|--|--------------------------|--|--|---|------------------|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |                          |  |  |   |                  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  |  | 2a. DATE OF DEATH        |  |  |   |                  | 2b. HOUR  |  |
| MELVIN Ray DAWSON   |  |  |  |  | September 24, 1980       |  |  |   |                  | 12:20 PM  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |                          | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR   |                  | IF UNDER 24 HRS.  |  |
| Male  |  | Caucasian  |  | May 21 1935  |                          | 45 YRS   |  | MONTHS DAYS   |                  | HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |                  |   |  |
| West Virginia   |  | U. S. A.   |  |  |                          | Baltimore County MD.   |  |   |                  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                  |   |  |
| Towson  |  | Greater Baltimore Medical Center   |  |  |                          | Carpenter  |  | Building  |                  |   |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |                          |  |  |   |                  |   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |                          | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS   |                  |   |  |
| Maryland  |  | Baltimore  |  | Essex  |                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 16 Dovetail Lane #21221   |                  |   |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME |  |  |   |                  |   |  |
| Granville NMN Dawson  |  |  |  |  | Margaret Ellen Waugh     |  |  |   |                  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |  | 16b. SOCIAL SECURITY NO. |  | 17. INFORMANT ADDRESS                              |   |                  |   |  |
| No  |  |  |  |  | 215-32-3979              |  | Pasadena, Md.<br>A Vernon L. Dawson 582 6th Street |   |                  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |                          |  |  |   |                  |   |  |
| PART I. DEATH WAS CAUSED BY   |  |  |  |  |                          |  |  |   |                  |   |  |
| IMMEDIATE CAUSE (a) Cerebral infarction   |  |  |  |  |                          |  |  |   |                  |   |  |
| 4349 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |                          |  |  |   |                  |   |  |
| (b) _____   |  |  |  |  |                          |  |  |   |                  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |                          |  |  |   |                  |   |  |
| (c) _____   |  |  |  |  |                          |  |  |   |                  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |                          |  |  |   |                  |   |  |
| Bronchopneumonia  |  |  |  |  |                          |  |  |   |                  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                          |  |  | 20a. AUTOPSY?   |                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|   |  |  |  |  |                          |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY  |                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |                  |   |  |
|   |  |  |  | HOUR A.M. MONTH DAY YEAR   |                          |  |  |   |                  |   |  |
|   |  |  |  | P.M. 19  |                          |  |  |   |                  |   |  |
| 21d. INJURY OCCURRED  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                          | 21f. LOCATION  |  |   |                  |   |  |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  |  |                          | CITY OR TOWN COUNTY STATE  |  |   |                  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from September 1, 19 80, to September 24, 19 80, that (I) (we) last saw the deceased alive on September 24, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |                          |  |  |   |                  |   |  |
| 22b. SIGNATURE  |  |  |  |  |                          | DEGREE   |  |   | 22c. DATE SIGNED |   |  |
| [Signature]   |  |  |  |  |                          |  |  |   | 9/24/80          |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |                          | 22e. ADDRESS   |  |   |                  |   |  |
| Ronald L. Sirota, M.D.  |  |  |  |  |                          | 6701 N. Charles St., Baltimore MD 21204  |  |   |                  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                          | 23d. LOCATION  |  | COUNTY  |                  | STATE   |  |
| Cremation   |  | 9/30/80  |  | Westview   |                          | Baltimore  |  | Maryland  |                  |   |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |                          | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |                  |   |  |
| Martin D. Lawson 10 W. Padonia Road   |  |  |  |  |                          | SEP 29 1980  |  | [Signature]   |                  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |  |   |  |                        | 8 0 2 2 1 0 9   |  |  |  |
|--|--|--|--|---|---|--|---|--|------------------------|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  |   |   |  |   |  |                        | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Robert E. Deily   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>09 02 80   |  |   |  | 2b. HOUR<br>10 A.<br>M |   |  |  |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>9 4 1906   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |                        | IF UNDER 24 HRS<br>HOURS MIN  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Coplay, Pa.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore Co. MD.                              |   |  |                        |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baldwin   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>5340 Glenheigh Road |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Steel worker, Ret. |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel                                     |                        |   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>5340 Glenheigh Rd. Baldwin, Md.  |  |                        |   |  |  |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baldwin  |   |  |   |  |                        |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jacob Edwin Deily  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alberta Neumeier                               |  |   |  |                        |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  |  |  |   | 16b. SOCIAL SECURITY NO.<br>188-10-4194   |  | 17. INFORMANT<br>ADDRESS Box 191 Sweet Air Rd.<br>Mrs. Charlotte F. Deily, Baldwin, Md. 21013 |  |                        |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>CONDITIONS, IF ANY, WHICH<br>GAVE RISE TO IMMEDIATE<br>CAUSE (a), STATING THE<br>UNDERLYING CAUSE LAST. |  |  |  |   |   |  |   |  |                        | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>12 Months  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |   |  |   |  |                        |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                        | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)         |   |  |                        |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                      |   |  |                        |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-23</u> , 19 <u>80</u> , to <u>9-2</u> , 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>8-26-80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |   |  |                        |   |  |  |  |
| 22b. SIGNATURE<br><u>J. R. Norris</u>  |  |  |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |   |  |   | 22c. DATE SIGNED<br>9-2-80.  |                        |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. John Norris   |  |  |  | 22e. ADDRESS<br>3421 Sweet Air Road   |   |  |   |  |                        |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>9-5-1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Johns Luth. Ch. Cem.  |   |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Sweet Air Balto. Md.                   |                        |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>E. F. LASSAHN FUNERAL HOME   |  |  |  | ADDRESS<br>11750 Belair Rd.   |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>SEP 8 1980  |                        | 25b. REGISTRAR'S SIGNATURE<br><u>Harry [Signature]</u>  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  | 8 0 2 2 1 1 0  |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |  |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Francis Charles DENGLER</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 22, 1980</b>   |  |   |  | 2b. HOUR<br><b>7:08 P.M.</b>   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 19 07</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | IF UNDER 72 HRS.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>self-employed</b>   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>lavern Owner</b> |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Bowleys Qts</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3827 Bay Drive 21220</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Peter J Dengler</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anne T Lindsey</b>  |  |  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>214-20-6298</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Gladys E. Dengler 3827 Bay Drive</b>  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-Pulmonary Arrest</b><br><b>410-</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Myocardial Infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>SUDDEN</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>SUDDEN</b> |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>SUDDEN</b>  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>September 22, 19 80</b> , to <b>September 22, 19 80</b> , that (X) (we) lost saw the deceased alive on <b>September 22, 19 80</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.   |  |  |  |   |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Leonard Berger MD</b>  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>9/22/80</b>                       |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Leonard Berger, M.D.</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr. 21237</b>  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>9/25/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Parkville Baltimore Md.</b>                    |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>LASSAHN FUNERAL HOME</b>   |  |  |  |   |  | ADDRESS<br><b>7401 Belair Road</b>   |  | 25. DATE REC'D. BY REGISTRAR<br><b>SEP 26 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   | 8 0 2 2 1 1 1  |  |   |  |
|---|--|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |   | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Charles C. Derkin   |  |  | 2a. DATE OF DEATH<br>9 12 80                                |  |  | 2b. HOUR<br>2:15P M   |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White  |   | 5 DATE OF BIRTH<br>June 26 1906  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>74                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pa.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD. |  |
| 10 CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GBMC 6701 N. Charles St. 21204 |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret. Masters Mates  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>& Pilots Assoc.        |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Florida  |  | 13b. COUNTY<br>Clearwater  |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13d. STREET ADDRESS<br>1119 Twin Lakes Lodge                |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Derkin   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Casey |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>WWII 161-01-5660   |   | 17 INFORMANT<br>Irene J. Derkin  |  | ADDRESS<br>Same   |  |
| 11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebro Vascular Accident<br>436-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/31 19 80, to 9/12 19 80, that (I) (we) lost above, (I) (we) did not view the body after death.   |  |  |   |  |  |   |  |
| 22b. SIGNATURE<br>Herminio P. Año DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |  |   |  |  | 22c. DATE SIGNED<br>9/12/80                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Herminio P. Año  |  |  |   | 22e. ADDRESS<br>6701 N. Charles St. 21204  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  | 23b. DATE<br>Sept. 15, 1980  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Greenmount   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc.  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>SEP 15 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                   |  |
| ADDRESS<br>5305 Harford Rd. Balt. Md  |  |  |   |  |  |   |  |

11-22-42



Handwritten signature or initials.

Over a 100

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |                                      |  |  |   |                   |  |  | 8022112           |           |  |
|--|--|---|--------------------------------------|--|--|---|-------------------|--|--|-------------------|-----------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   | 2a. DECEASED NAME<br>(TYPE OR PRINT) |  |  |   | 7a. DATE OF DEATH |  |  |                   | 2b. HOUR  |  |
|  |  |   | YETTA DIAMOND                        |  |  |   | 9-23-80           |  |  |                   | 3:10 P.M. |  |
| 3 SEX  |  | 4 RACE  |                                      | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |                   | 8 IF UNDER 1 YEAR  |  | 9 IF UNDER 74 HRS |           |  |
| FEMALE   |  | WHITE   |                                      | AUG. 17, 1904  |  | 76 YRS.   |                   | MONTHS DAYS  |  | HOURS MIN.        |           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |                                      | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |                   |  |  |                   |           |  |
| RUSSIA   |  | USA   |                                      |  |  | BALTIMORE COUNTY MD.  |                   |  |  |                   |           |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                      |  |  |   |                   |  |  |                   |           |  |
| RANDALLSTOWN   |  | BALTIMORE COUNTY GEN. HOSPITAL  |                                      |  |  |   |                   |  |  |                   |           |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                                      |  |  |   |                   |  |  |                   |           |  |
| HOUSEWIFE  |  | AT HOME   |                                      |  |  |   |                   |  |  |                   |           |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |                                      |  |  |   |                   |  |  |                   |           |  |
| 13a. STATE   |  | 13b. COUNTY   |                                      | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |                   | 13e. STREET ADDRESS  |  |                   |           |  |
| MARYLAND   |  | BALTIMORE   |                                      | BALTO.   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                   | 3234 SOUTHGREEN RD. #21207                                     |  |                   |           |  |
| 14 FATHER'S NAME   |  |   |                                      | 15. MOTHER'S MAIDEN NAME   |  |   |                   |  |  |                   |           |  |
| FIRST MIDDLE LAST<br>SAMUEL LOSIN  |  |   |                                      | FIRST MIDDLE LAST<br>TILLIE TEROSNITZKY  |  |   |                   |  |  |                   |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |                                      | 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT  |                   | MR. BERNARD DIAMOND  |  |                   |           |  |
| NO   |  |   |                                      | 219-10-8818  |  | 3234 SOUTHGREEN RD. BALTO., MD                                      |                   | 21207  |  |                   |           |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u><br>4140<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Arteriosclerotic heart disease</u><br>(c) <u>With heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>days</u><br><u>years</u> |  |   |                                      |  |  |   |                   |  |  |                   |           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |                                      |  |  |   |                   |  |  |                   |           |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                      |  |  | 20a. AUTOPSY?   |                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                   |           |  |
|  |  |   |                                      |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                   |           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |                   |  |  |                   |           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |                   |  |  |                   |           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-21-</u> 19 <u>80</u> , to <u>9-23-</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>9-23-</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |                                      |  |  |   |                   |  |  |                   |           |  |
| 22b. SIGNATURE<br><u>Soonchal Hong</u>   |  |   |                                      | DEGREE   |  |   |                   | 22c. DATE SIGNED<br><u>9-23-80</u>                             |  |                   |           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>SOONCHUL HONG</u>  |  |   |                                      | 22e. ADDRESS<br><u>Baltimore County General Hospital</u>   |  |   |                   |  |  |                   |           |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |                                      | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |                   |  |  |                   |           |  |
| BURIAL   |  | 9/24/80   |                                      | HEBREW FRIENDSHIP  |  | BALTIMORE MARYLAND  |                   |  |  |                   |           |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><u>SOL LEVINSON &amp; BROS., INC.</u>   |  |   |                                      |  |  | 25a. DATE REC'D. BY REGISTRAR                                       |                   | 25b. REGISTRAR'S SIGNATURE<br><u>Betty McCreedy</u>            |  |                   |           |  |
| 6010 REISTERSTOWN RD., BALTO., MD 21215  |  |   |                                      |  |  | SEP 26 1980   |                   |  |  |                   |           |  |



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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |   |  |  |  |  | REG. NO.<br>8022113                             |  |
|--|--|---|--|--|---|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   | I. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>William H. Dietz |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9 16 80 |  |  | 2b. HOUR<br>10:50AM                             |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>June 4, 1918  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. HOUR<br>10:50AM                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                         |  |  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GBMC 6701 N. Charles St. 21204 |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Martin Marietta  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Production  |  |   |  |
| 13a. STATE<br>Maryland   |  |   | 13b. CITY OR TOWN<br>Baltimore   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13d. STREET ADDRESS<br>1734 Aberdeen Road      |  |  |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles L. Dietz  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alice B. Harr   |   |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II  |  | 17 INFORMANT<br>Mrs. Marion Virginia Dietz   |   | ADDRESS<br>Same as #13.  |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u><br>DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Metastatic Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF, (c) <u>Ca of the Kidney</u>   |  |   |  |  |   |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |  |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/19</u> 19 <u>80</u> , to <u>9/16</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>9/16</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Dr. Alvaro Jerez</i>  |  |   |  | DEGREE   |   |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>9/16/80                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Alvaro Jerez  |  |   |  | 22e. ADDRESS<br>6701 N. Charles St. 21204  |   |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Sept. 19, 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Cem.  |   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cockeysville Balto., Md.   |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc.  |  |   |  | ADDRESS<br>1050 York Road Towson, Md. 21204  |   |  |  | 25a. DATE REC'D BY REGISTRAR<br>SEP 18 1980  |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |   |   |  |   |  | 8022114 |  |
|--|--|---|--|--|---|---|--|---|--|---------|--|
| 1- FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |  |  |   |   |  |   |  |         |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>Di Fatta, (NM) Frank  |  |   |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br>9/14/80  |   |  | 2b HOUR MIN<br>5 AM   |  |         |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>2 14 07   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN      |  |         |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>ITALY  |  | 7b CITIZEN OF WHAT COUNTRY?<br>ITALY  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CO. MD.                                    |  |   |  |         |  |
| 10 CITY OR TOWN OF DEATH<br>CATONSVILLE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Spring Grove State Hospital |  |  |   | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>BARBER                      |  | 12b KIND OF BUSINESS OR INDUSTRY                              |  |         |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE MD  |  | 13b CITY OR TOWN BALTO  |  | 13c CITY OR TOWN BALTO   |   | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e STREET ADDRESS<br>7404 Old Harford Rd 21234               |  |         |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Francesco DiFatta  |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Teresa DiFrancesca  |   |   |  |   |  |         |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b SOCIAL SECURITY NO<br>217-34-9334   |  | 17 INFORMANT Wife:<br>Josephine DiFatta  |   | ADDRESS Balt., Md. 21234<br>7404 Old Harford Rd.  |  |   |  |         |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Blood pneumonia Related</u><br>1369<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>INFECTION</u><br>(c) <u>Age</u>  |  |   |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 week</u>  |         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><u>Diabetes Mellitus</u>   |  |   |  |  |   |   |  |   |  |         |  |
| 19a DATE OF OPERATION  |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   |   | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |  |         |  |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |         |  |
| 22a. I certify that (we) (this hospital) attended the deceased from <u>10/04</u> , 19 <u>79</u> , to <u>9/14/</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>9/13/80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |   |  |   |  |         |  |
| 22b. SIGNATURE<br>Curt Ruck, Jr. M.D.  |  |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br>9/14/80                                   |  |         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>OLIFF RATLIFE, JR.  |  |   |  |  | 22e ADDRESS<br>5712 WEST VIEW MALL  |   |  |   |  |         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Entombment  |  |   | 23b. DATE<br>Sep 17 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Most Holy Redeemer  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |  |         |  |
| 24 FUNERAL DIRECTOR NAME<br>Leonard J. Ruck, Inc.  |  |   |  |  | ADDRESS<br>Baltimore, Maryland  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 15 1980                  |  |         |  |
|  |  |   |  |  |   |   |  | 25b. REGISTRAR'S SIGNATURE<br>D. J. Brady                     |  |         |  |



Office of the Secretary

MEMORANDUM  
TO: THE SECRETARY  
FROM: [illegible]  
SUBJECT: [illegible]

Very truly yours,  
[illegible signature]  
[illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 0 2 2 1 1 5<br>REG. NO.  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CHARLOTTE S DILLEY</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>20</b> YEAR <b>80</b>   |  |  |  | 2b. HOUR<br><b>6:50PM</b>  |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>06</b> DAY <b>23</b> YEAR <b>88</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b>   |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   |  | IF UNDER 74 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CO.</b> MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GREATER BALTO MED CENTER</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                           |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE <b>Maryland</b> 13c. COUNTY <b>Baltimore</b>  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>3106 Rosalie Ave</b>   |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>CHARLOTTE</b> MIDDLE <b>S</b> LAST <b>DILLEY</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ethel</b> MIDDLE <b>F</b> LAST <b>Golaner</b>  |  |  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b> 16b. SOCIAL SECURITY NO. <b>220-34-7392</b>  |  |  |  |
| 17. INFORMANT<br><b>Mrs Ethel F Golaner</b>  |  |  |  | ADDRESS<br><b>Same</b>  |  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>VENTRICULAR ARYTHMINS</b> <b>DIAGNOSED ON ADM.</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>10 YRS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>HYPERTENSION</b> <b>30 YRS</b> |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>9-10-80</b>   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>ARTERIOSCLEROTIC HEART DISEASE</b>   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>9-10-80</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                                 |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET <b>6701 N CHARLES ST</b> CITY OR TOWN <b>BALTO</b> COUNTY <b>BALTO</b> STATE <b>MD</b> |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-20-80</b> , to <b>9-20-80</b> , that (I) (we) last saw the deceased alive on <b>9-20-80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>R.M. DeCastro MD</b>  |  |  |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>9/20/80</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR RAYMOND DE CASTRO MD</b>  |  |  |  | 22e. ADDRESS<br><b>6701 N CHARLES ST BALTO 21204</b>  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  |  | 23b. DATE<br><b>9/23/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE <b>MD</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Leonard J Ruck Inc.</b> ADDRESS <b>Baltimore, Maryland</b>   |  |  |  | 25. DATE RECEIVED BY REGISTRAR<br><b>SEP 22 1980</b>  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |



00: 57: 45

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE REGISTRAR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                      |  |   |  |   |  |  |  | REG. NO. 70 22116  |  |  |  |   |  |
|---|--|----------------------|--|---|--|---|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Nicola</i> FIRST <i>NMN</i> MIDDLE <i>D.</i> LAST <i>MARINO</i>   |  |                      |  |   |  |   |  |  |  | 2b. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <i>9 14 80</i> |  | 2d. HOUR <i>3</i> M  |  |   |  |
| 3. SEX <i>male</i>  |  | 4. RACE <i>white</i> |  | 5. DATE OF BIRTH MONTH <i>oct</i> DAY <i>31</i> YEAR <i>1901</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <i>78</i> YRS                                   |  | IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>   |  | IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>  |  | 2c. DATE PRONOUNCED DEAD <i>9 15 80</i>  |  | 2d. HOUR <i>11</i> M                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Italy</i>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTO Co</i> MD.                         |  |   |  |
| 10. CITY OR TOWN OF DEATH <i>Hillendale Pk Md</i>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>8204 Bonair Rd 21234</i> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Brick Layer</i>   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>Cont.</i>                                   |  |   |  |
| 13a. STATE <i>MD</i>  |  |                      |  | 13b. COUNTY <i>Balto.</i>   |  | 13c. CITY OR TOWN <i>Hillendale Pk</i>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS <i>8204 Bonair Rd 21234</i>  |  |  |  |   |  |
| 14. FATHER'S NAME FIRST <i>Camille</i> MIDDLE <i>D.</i> LAST <i>Marino</i>  |  |                      |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST <i>Charm</i> MIDDLE <i>D.</i> LAST <i>Parula</i> |  |  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? [YES, NO, OR UNKNOWN] <i>No</i>  |  |                      |  | 16b. SOCIAL SECURITY NO. <i>217-04-7949</i>   |  | 17. INFORMANT <i>Daughter:</i> ADDRESS <i>Connie Krueger 4762 Shamrock Ave.</i> |  |  |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Atherosclerotic Cardiovascular Disease</i><br><i>4292</i><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  |                      |  |   |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>unk</i> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |                      |  |   |  |   |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION <i>X</i>   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                      |  |   |  |   |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <i>John C. Hyle</i>  |  |                      |  | TITLE (SPECIFY) <i>Dpt</i>  |  |   |  | DATE SIGNED <i>9-15-80</i>   |  |  |  | MEDICAL EXAMINER   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <i>JOHN C. Hyle</i>   |  |                      |  | ADDRESS <i>7527 Belair Rd Balto 21236 Md</i>  |  |   |  |  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>   |  |                      |  | 23b. DATE <i>9/18/80</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Moreland Memorial Park</i>                |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME <i>Leonard J. Ruck, Inc.</i>  |  |                      |  | ADDRESS <i>5305 Harford Rd. 21214</i>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <i>SEP 16 1980</i>   |  |  |  | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>                                    |  |   |  |

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UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

(M)

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(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |   |  |  |  |                                  | 80   | 22 | 11 | 17 |
|--|--|--|--|---|---|--|--|--|----------------------------------|--|----|----|----|
| 1. FOR STATE REGISTRAR   |  |  |  |   |   |  |  |  |                                  | REG. NO.                                     |    |    |    |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Frank P. DIRISIO   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>September 5, 1980 |  |  |  | 2b. HOUR<br>7:10 P. <sup>M</sup> |  |    |    |    |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>8 - 20 - 1901  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |                                  | IF UNDER 24 HRS.<br>HOURS MIN.               |    |    |    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>ITALY   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |  |                                  |  |    |    |    |
| 10. CITY OR TOWN OF DEATH<br>MARYLAND  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQ. Hosp. |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>FOREMAN   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>CORST. CO.  |                                  |  |    |    |    |
| 13a. STATE<br>MD.  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BAHOTO   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>3518 PEBHAM AVE   |                                  |  |    |    |    |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>JOSEPH DIRISIO  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>CORISIA CHIEFFERDI   |  |   |   |  |  |  |                                  |  |    |    |    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>215-10-2818  |  | 17. INFORMANT<br>GERTRUDE DIRISIO   |   | ADDRESS<br>3518 PEBHAM AVE   |  |  |                                  |  |    |    |    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio-respiratory arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Right cerebro-vascular accident<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>436-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |   |  |  |  |                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |    |    |    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |   |  |  |  |                                  |  |    |    |    |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                  |  |    |    |    |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |                                  |  |    |    |    |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |                                  |  |    |    |    |
| 22a. I certify that (this hospital) attended the deceased from August 17 80 to September 5 80, that (I/we) last saw the deceased alive on September 5 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. My (we) did (did not) view the body after death.   |  |  |  |   |   |  |  |  |                                  |  |    |    |    |
| 22b. SIGNATURE<br>Hattie M. Faison   |  |  |  |   |   | DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>9/5/80   |                                  |  |    |    |    |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Hattie M. Faison  |  |  |  |   |   | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237  |  |  |                                  |  |    |    |    |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>ENTOMBMENT  |  | 23b. DATE<br>9-9-80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GARDENS OF FAITH  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BAHOTO MD.   |  |  |                                  |  |    |    |    |
| 24. FUNERAL DIRECTOR<br>NAME<br>John M. Weber & Sons Inc.  |  | ADDRESS<br>401 S. CHESTER ST.  |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 8 1980   |   | 25b. REGISTRAR'S SIGNATURE<br>Hattie M. Faison   |  |  |                                  |  |    |    |    |



1152 18

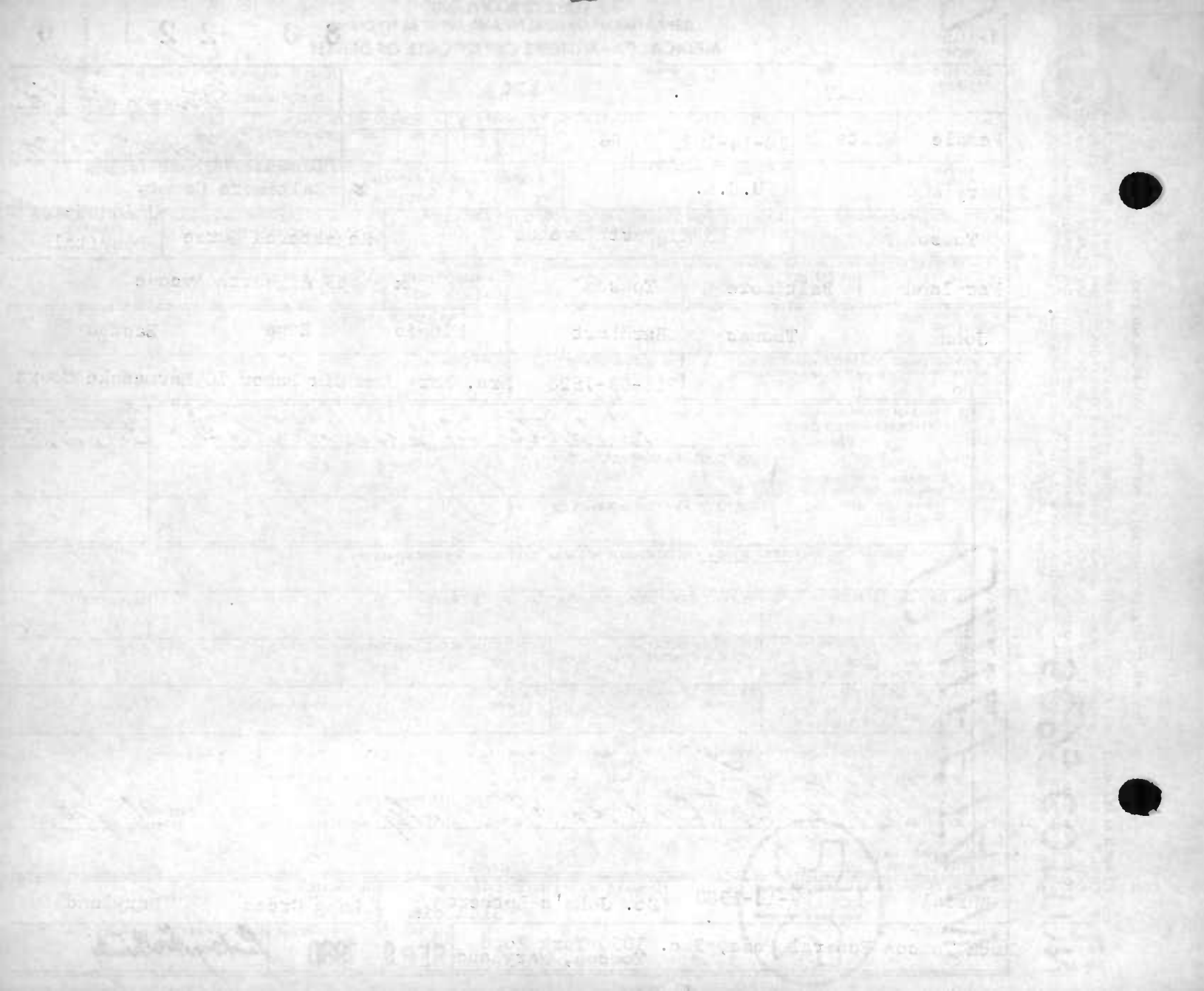


2 Oct

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| 1- STATE REGISTRAR<br>1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE E. LAST DIX<br>2a. DATE KNOWN OF DEATH ESTI- MATED MONTH DAY YEAR 8 0 22 1 18<br>2b. DATE OF DEATH ESTI- MATED MONTH DAY YEAR 8 0 22 1 18<br>3. SEX Female 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR 10-14-1915 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 64 7. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH Towson 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN STATE FACILITY, GIVE STREET ADDRESS) 65 Alburch Avenue 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered Nurse 12b. NAME OF BUSINESS OR INDUSTRY Union Memorial Hospital   |  |  |  |  |  |  |  |  |  |
| 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Towson 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 65 Alburch Avenue  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST John MIDDLE Thomas LAST Barnhart 15. MOTHER'S MAIDEN NAME Minnie Edna Easton   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 218-09-7528 17. INFORMANT ADDRESS Mrs. Mary Ann Dix Huber 10 Marmaduke Court  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: 410- IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> (b) <u>Sudden</u> (c) <u>Sudden</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Charles F. Brown</u> M.D. TITLE (SPECIFY) MEDICAL EXAMINER DATE SIGNED 9/1/80  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) ADDRESS  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL Burial 23b. DATE 9-10-1980 23c. NAME OF CEMETERY OR CREMATORY St. John's Lutheran Blenheim 23d. LOCATION CITY OR TOWN COUNTY STATE Long Green Maryland   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 25a. DATE REC'D. BY REGISTRAR SEP 9 1980 25b. REGISTRAR'S SIGNATURE <u>Henry McBrady</u>   |  |  |  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 1 1 9

|   |                  |  |  |   |  |
|---|------------------|--|--|---|--|
| 1. FOR STATE REGISTRAR  |                  | 2a. DATE OF DEATH  |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Charles D. Doherty  |                  | MONTH DAY YEAR<br>Sept. 22, 1980   |  | 5:45 P M  |  |
| 3. SEX<br>Male  | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept 25 1892   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ireland  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.   |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Manor Care - Ruxton |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Plumbing & Heating   |                  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-   |  |   |  |
| 13a. STATE<br>Md.   |                  | 13b. CITY OR TOWN<br>Balto.  |  | 13c. STREET ADDRESS<br>4216 Parkside Drive  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Patrick Doherty   |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marjorie McCool   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes   |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW I  |  | 17. INFORMANT ADDRESS<br>Kathleen Doherty (wife) same address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u><br>185-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>METASTATIC CA OF PROSTATE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): |                  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| MEDICAL CERTIFICATION   |                  |  |  |   |  |
| 19a. DATE OF OPERATION  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT 17</u> 19 <u>80</u> to <u>SEPT 22</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>8-25</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |                  |  |  |   |  |
| 22b. SIGNATURE<br><u>Dr. Marcio Menendez</u>  |                  | DEGREE<br><u>MD</u>  |  | 22c. DATE SIGNED<br><u>9/23/80</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Marcio Menendez  |                  | 22e. ADDRESS<br>Union Memorial Hosp.   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |                  | 23b. DATE<br>9/26/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.  |                  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Primunek Funeral Home, Inc. 3331 Brehms Lane Balto. Md. 21213   |                  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 23 1980   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Patricia Hahn</u>  |  |



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FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 2 2 1 2 0

|  |  |  |   |   |  |  |  |   |  |
|--|--|--|---|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ralph R. Donatelli  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Sept. 18, 1980 |   |  | 2b. HOUR<br>11:50a M   |  |   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>October 8, 1896   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>ITALY  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph Hospital |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>TAILOR   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>CLOTHING FACTORY           |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  |  |   | 13b. CITY OR TOWN<br>BALTO  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br>4704 RENWICK AVE.                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ANTHONY DONATELLI  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ADELINA TOLEDO  |   |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-09-4962   |   | 17. INFORMANT<br>ADDRESS<br>MRS. CONCETTA DONATELLI   |  |  |  | SAME  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u><br>410 -<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Acute myocardial infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>Congestive heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><u>Arteriosclerotic cardiovascular disease</u> |  |  |   |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Sept. 18, 1980</u> , to <u>Sept. 18, 1980</u> , that (I) (we) last saw the deceased alive on <u>Sept. 18, 1980</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did not) view the body after death.  |  |  |   |   |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Jose Hernandez</u>  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>Sept. 18, 1980                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jose Hernandez, M.D.  |  |  |   | 22e. ADDRESS<br>7620 York Rd. Towson, Md. 21204   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br>BURIAL  |  | 23b. DATE<br>10-22-1980  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLY REDEEMER BALTO   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO MD   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>J. Walter Exblis   |  |  |   | ADDRESS<br>5444 BELAIR Rd   |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 24 1980   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



*[Faint, illegible handwritten text covering the majority of the page, likely bleed-through from the reverse side.]*





FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |                 |                  |  |  |   |  |   |                    |  |  |  |  |   |                     |  |  |
|--|--|-----------------|------------------|--|--|---|--|---|--------------------|--|--|--|--|---|---------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                 | FIRST<br>Charles |  |  | MIDDLE<br>Clinton   |  |   | LAST<br>Dorsey III |  |  | 2a. DATE KNOWN OF DEATH<br>ESTI- MATED <input checked="" type="checkbox"/> 9 27 1980 |  |   | 2b. HOUR<br>M       |  |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White |                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 9, '62  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>18 YRS.                     |  | IF UNDER 1 YR.<br>MONTHS DAYS   |                    | IF UNDER 24 HRS.<br>HOURS MIN  |  | 7c. DATE PRONOUNCED DEAD<br>9 27 1980  |  |   | 7d. HOUR<br>4:20A M |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |                 |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                    |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                        |  |   |                     |  |  |
| 10. CITY OR TOWN OF DEATH<br>21204   |  |                 |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Loch Raven Drive |  |   |  |   |                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Student |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Education  |                     |  |  |
| 13a. STATE<br>Maryland   |  |                 |                  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>21234  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                    | 13e. STREET ADDRESS<br>8608 Quentin Avenue                               |  |  |  |   |                     |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Clinton Dorsey, Jr.  |  |                 |                  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Jacqueline Dolch |  |   |                    |  |  |  |  |   |                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                 |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----   |  | 17. INFORMANT<br>ADDRESS<br>Charles C. Dorsey, Jr. Balto., Md.    |  |   |                    |  |  |  |  |   |                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chest trauma</u><br>8160 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. }<br>(b) _____ DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                 |                  |  |  |   |  |   |                    |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                     |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |  |                 |                  |  |  |   |  |   |                    |  |  |  |  |   |                     |  |  |
| 19a. DATE OF OPERATION   |  |                 |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |                    |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |                     |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                 |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>3:30 PM 9 27 1980   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>driver of auto lost control  |                    |  |  |  |  |   |                     |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                 |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Loch Raven Drive, Balto., MD.  |                    |  |  |  |  |   |                     |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |                 |                  |  |  |   |  |   |                    |  |  |  |  | 22b. Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                     |  |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>   |  |                 |                  | TITLE (SPECIFY)<br>Deputy Chief  |  |   |  |   |                    |  |  | DATE SIGNED<br>9/27/80   |  |   |                     |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, M.D.  |  |                 |                  | ADDRESS<br>111 Penn St. Balto., MD.  |  |   |  |   |                    |  |  |  |  |   |                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                 |                  | 23b. DATE<br>Sept. 30, '80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Mem. Park          |  |   |                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co., Maryland    |  |  |  |   |                     |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>William E. Johnson   |  |                 |                  | ADDRESS<br>8521 Loch Raven Blvd.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 29 1980  |                    |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Barry Halbrudy</i>                                  |  |   |                     |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 80 22122   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Rubin Alphonsa Dorsey</i>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>9 7 80</i>   |  |   |   |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>Negro</i>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>6 16 98</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><i>82 YRS.</i>  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Stella Maris Hospice</i>             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Farmer</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <i>Maryland</i> 13b. COUNTY <i>✓</i>  |  |   |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Unknown</i>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Rachel Dorsey</i>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>NO</i>  |  | 16b. SOCIAL SECURITY NO<br><i>210-30-4557</i>   |  | 17. INFORMANT ADDRESS<br><i>Stella Maris Hospice Dulaney Valley Rd. Balto, Md. 21204</i>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Metastatic Cancer of the Larynx</i><br>1619<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 yr &amp; 5 months</i> |  |   |  |   |  |   | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>June 26</i> 19 <i>79</i> , to <i>September 7</i> 19 <i>80</i> , that (I) (we) lost saw the deceased alive on <i>September 4</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |   |
| 22b. SIGNATURE <i>Eh</i>  |  | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><i>9/7/80</i>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>E. Lee Robbins</i>  |  |   |  | 22e. ADDRESS<br><i>1205 York Rd. Towson, Md. 21204</i>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>Sept. 11, '80</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>St. Mary's</i>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Newport Charles, Md.</i>  |   |
| 24. FUNERAL DIRECTOR<br><i>Leon Thornton</i>  |  |   |  | 25. DATE RECEIVED BY FUNERAL DIRECTOR<br><i>SEP 11 1980</i>   |  |   |   |
| NAME<br><i>Thornton Funeral Home</i>  |  |   |  | ADDRESS<br><i>R.R. 1 Box 115 Pomonkey, Md.</i>  |  |   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |  |   |   |   |  |   | 8  | 0 | 2  | 2  | 1  | 2 | 3 |                           |  |
|---|--|--|---|--|---|---|---|--|---|--|---|--|--|--|---|---|---------------------------|--|
| 1. FOR STATE REGISTRAR  |  |  |   |  |   |   |   |  |   | REG. NO.   |   |  |  |  |   |   |                           |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Aileen Doyle</b>  |  |  |   |  |   |   |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>9 23 80</b>   |   |  |  |  |   |   | 2b. HOUR<br><b>10:15a</b> |  |
| 3. SEX<br><b>Female</b>   |  |  | 4. RACE<br><b>White</b>   |  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12 4 1885</b>   |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>94</b> YRS.   |  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>94</b>        |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>10:15</b> |   |   |                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |   |  |  |  |   |   |                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Little Sisters of the Poor</b> |  |   |   |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Seamstress</b>   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                |  |   |   |                           |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   | 13e. STREET ADDRESS<br><b>3305 Guilford Avenue</b> |  |  |   |   |                           |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>James Doyle</b>   |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Frances Ward</b> |   |   |  |   |  |   |  |  |  |   |   |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>213-32-7342</b>  |  |   | 17. INFORMANT ADDRESS<br><b>Sr. Claire 601 Maiden Choice Lane</b>   |   |  |   |  |   |  |  |  |   |   |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br><b>410 -</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary heart failure - Pulmonary</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>senescence. Very old A.S.E.O.</b> |  |  |   |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |  |  |   |   |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |   |  |   |   |   |  |   |  |   |  |  |  |   |   |                           |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |  |   |   |                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |   |  |   |  |  |  |   |   |                           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |   |  |  |  |   |   |                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 28</b> , 19 <b>80</b> , to <b>Sept 23</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>Sept 23</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |   |   |   |  |   |  |   |  |  |  |   |   |                           |  |
| 22b. SIGNATURE<br><b>Stanley Ankudars</b> DEGREE<br><b>M.D.</b>   |  |  |   |  |   |   |   |  |   | 22c. DATE SIGNED<br><b>9-24-80</b>   |   |  |  |  |   |   |                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STANLEY ANKUDARS</b>  |  |  |   |  |   |   |   |  |   | 22e. ADDRESS<br><b>1101 Maiden Choice Ln Baltimore</b>   |   |  |  |  |   |   |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>9/25/80</b>   |  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NEW CATHEDRAL CEMETERY</b>   |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE</b>                                     |  |   |  |  |  |   |   |                           |  |
| 24. FUNERAL DIRECTOR NAME<br><b>HUBBARD FUNERAL HOME, INC.</b> ADDRESS<br><b>4107 WILKENS AVE.</b>  |  |  |   |  |   |   |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 25 1980</b>  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |  |   |   |                           |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |  |   |  |  |
|--|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EDITH DRESCHER</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 - 12 - 80</b>              |   |  | 2b. HOUR<br><b>1737</b>  |   |  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 25 1899</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MO</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RET</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |  |   |  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>BALTO</b>   |  | 13c. CITY OR TOWN<br><b>ESSEX</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET ADDRESS<br><b>107 S. STUART ST.</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM BARBER</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARGARET BUTSCHKY</b>   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>-</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>ETHEL LION ABOVE</b>  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>VENTRICULAR ARREST</b><br><b>410-</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MYOCARDIAL INFARCTION</b> Days<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 DAYS</b> |  |   |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>10 50 19 80</b>  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10 50</b> to <b>12 50</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive or above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Richard D. Bressler</b>   |  |   | DEGREE   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>12/28/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Richard D. Bressler</b>  |  |   | 22e. ADDRESS<br><b>7401 OSIA DR 21204</b>                              |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>9/16/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MORELANDS</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>CONNELLY F.H.</b>   |  |   |  | ADDRESS<br><b>300 MAACE AVE</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 19 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Henry M. M...</b>   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 1 2 5

REG. NO.

|  |  |   |  |   |   |   |   |  |  |  |
|--|--|---|--|---|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James Cleveland Duckett Jr.   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>September 8, 1980               |   |   | 2b. HOUR<br>12:15 AM  |   |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 23, 1911   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                      |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>419 Neepier Road 21228 |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Store Manager |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Retail Food   |  |  |
| 13a. STATE<br>Maryland   |  |   | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Catonsville  |   | 13d. STREET ADDRESS<br>419 Neepier Road 21228                     |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Cleveland Duckett Sr.  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Martha Thompson  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  |   | 16b. SOCIAL SECURITY NO.<br>WW II<br>212-07-6297                       |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Carol A. Welkner Balt, Md. 21228   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASHD and severe C.O.P.D</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>4140</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>minutes<br>Years.  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |   |  |   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/13/1978</u> to <u>9/8/1980</u> , that (I) (we) last saw the deceased alive on <u>9/3/1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |   |   |  |  |  |
| 22b. SIGNATURE<br><u>Adnan M. Sonmez</u>   |  |   |  |   | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br>9/9/80   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Adnan M. Sonmez, M.D.   |  |   |  |   | 22e. ADDRESS<br>500 N. Rolling Rd. Balt., Md. 21228   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   | 23b. DATE<br>9/10/80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>MacNabb Funeral Home   |  |   |  |   | ADDRESS<br>Catonsville, Md.   |   | 25a. DATE REC'D. BY REGISTRAR<br>SEP 15 1980                      |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u> |  |

SECRET



[Faint, mostly illegible text covering the main body of the page, possibly a memorandum or report.]

*[Handwritten signature]*

SEP 12 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 1 2 6

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 9 23 80   |  | 6:55AM  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| MALE   |  | WHITE  |  | MONTH DAY YEAR<br>02 08 07  |  | 73 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| WEST VIRGINIA  |  | U.S.A.   |  |   |  | BALTIMORE COUNTY MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| BALTIMORE  |  | GBMC-6701 N. CHARLES ST.   |  | CARPENTER   |  | CARPENTRY   |  |
| 13a. STATE   |  | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS   |  |
| BALTIMORE  |  | MARYLAND   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 409 S. Benson Street 21230  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  |
| ASHFORD  |  | DUGGER   |  | NO  |  | 215-05-5911   |  |
| 17. INFORMANT  |  | ADDRESS  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiorespiratory Arrest<br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Carcinoma of Lung<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  | 21g. DATE SIGNED  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-2 80 to 9-23 80, that (I) (we) last saw the deceased alive on 9-23 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE   |  | 22c. DATE SIGNED  |  | 22d. ADDRESS  |  |
| MICHAEL B. GRIECO  |  | GRIECO M.D.  |  | 9/23/80   |  | GREATER BALTIMORE MEDICAL CENTER.                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |
| BURIAL   |  | 9/25/80  |  | Glen Haven Memorial Pk.   |  | Glen Burnie Maryland  |  |
| 24. FUNERAL DIRECTOR NAME  |  | 24b. ADDRESS   |  | 24c. DATE REC'D. BY REGISTRAR   |  | 24d. REGISTRAR'S SIGNATURE  |  |
| Hubbard Funeral Home, Inc.   |  | 4107 Wilkens Ave.  |  | SEP 25 1980   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 0 2 2 1 2 7   |  |  |   |
|--|--|---|--|---|--|--|---|
| FOR<br>1 - STATE<br>REGISTRAR  |  |   |  | REG. NO.  |  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Thomas M. Eckert   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Sept. 10, 1980   |  |  |   |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb 11 1894   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86<br>YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |   |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Josephs Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Meat Culler   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Food Store  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  | 13b. COUNTY<br>BALTO.   |  | 13c. CITY OR TOWN<br>PARKVILLE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Eckert  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lillian C. Eckert  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-01-7685  |  | 17. INFORMANT<br>ADDRESS<br>Lillian C. Eckert Same  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1952 Abdominal Carcinoma<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) with metastasis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>9 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 9, 1980, to Sept. 10, 1980, that (I) (we) last saw the deceased alive on Sept. 10, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                |  |   |  |   |  |  |   |
| 22b. SIGNATURE<br>A.H. Ghiladi   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>9-10-80  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A.H. GHILADI, M.D.  |  |   |  | 22e. ADDRESS<br>7600 OSLER Dr. Towson 21204   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>9/13/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GARDEN OF FAITH   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO MD   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Evan's Funeral Chapel  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 15 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |   |
| ADDRESS<br>8802 Harford Rd   |  |   |  |   |  |  |   |



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*[Faint, illegible handwritten text]*

*[Faint, illegible handwritten text]*



FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 1 2 8

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Dolly Myers Edwards  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9 - 20-80 |   |  | 2b. HOUR<br>11:40 <sup>am</sup>  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 11 1909   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>No. Carolina   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. County MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2814 Vermont Ave.-21227 |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  |
| 13a. STATE<br>Maryland  |  |  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Balto. Highlands  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Augusta White  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>239-13-0918   |  | 17. INFORMANT<br>ADDRESS<br>Sereata Bennett-2814 Vermont Ave. 21227   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive heart failure</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <u>Arteriosclerotic CVD, advanced</u><br>(c) <u></u> |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22. I certify that (a) this hospital attended the deceased from <u>12/22/78</u> to <u>9/20/80</u> , that (b) (we) lost <u>12/22/78</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) did (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22a. SIGNATURE<br><u>Herbert J. Levickas</u> MD.  |  |  |  | 22b. DATE SIGNED<br>9/20/80   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Herbert J. Levickas, M.D.  |  |  |  | 22e. ADDRESS<br>5404 East Drive x Balto. Md. 21227  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>9/23/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Raleigh Nat. Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Raleigh N.C.   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>George J. Gonce 4001 Ritchie Highway  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 23 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><u>George J. Gonce</u>   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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*Handwritten signature*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 1 2 9

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |   |  |   |  |   |  |
|--|--|---|---|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>FRANK EDWARDS</b>                        |  |   | 2a. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>9</b> YEAR <b>80</b> |   |  | 2b. HOUR<br><b>8:00 A M</b>   |  |   |  |   |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>NEGRO</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>03</b> DAY <b>06</b> YEAR <b>14</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |  | 7. IF UNDER 24 HRS<br>HOURS <b>0</b> MIN <b>0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Co.</b> MD.                                |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Balto. Co. Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Nurse</b>                |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hospital</b> |   |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Carroll</b>   |   | 13c. CITY OR TOWN<br><b>Henryton</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>Box 4</b>                 |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Walter</b> MIDDLE <b>Edwards</b> LAST <b>Edwards</b> |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Rosa</b> MIDDLE <b>?</b> LAST <b>-</b>   |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   |   | 16b. SOCIAL SECURITY NO<br><b>214 182521</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Vadie Edwards Henryton, Md.</b>                                  |  |   |  |   |  |

|  |  |   |  |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardio Pulmonary arrest</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Possible Pulmonary emboli</b>                          |  |   |  |
| (c) <b>Hepatic coma secondary to cirrhosis</b>   |  |   |  |

|   |  |   |  |
|---|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |
| 19a. DATE OF OPERATION<br><b>-</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>-</b> <b>19</b>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>-</b>  |  | 21d. LOCATION<br>STREET <b>-</b> CITY OR TOWN <b>-</b> COUNTY <b>-</b> STATE <b>-</b>   |  |
| 21e. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21f. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>-</b>  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9-3-</b> 19 <b>80</b> , to <b>9-9-</b> 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>9-9-</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |
| 22a. SIGNATURE<br><b>Juan C. Ruffier MD</b>   |  | 22b. DATE SIGNED<br><b>9/9/80</b>   |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JUAN C. RUFFIER</b>   |  | 22d. ADDRESS<br><b>Baltimore County General Hospital</b>  |  |

|   |  |                             |  |  |  |  |  |
|---|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                       |  | 23b. DATE<br><b>9-13-80</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>West Liberty Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN <b>Manothville</b> COUNTY <b>Howard</b> STATE <b>Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Harry W. Haight</b> ADDRESS <b>Sylmarville, Md.</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 15 1980</b>                |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia McCreedy</b>                                 |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |                        |  |  | 8 0 2 2 1 3 0<br>REG. NO.  |  |  |   |
|---|------------------------|--|--|--|--|--|---|
| 1. FOR STATE REGISTRAR  |                        |  |  |  |  |  |   |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>GERTRUDE K. EILERS</b>  |                        |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 25 80</b>   |  | 2b HOUR<br><b>5:05A<sub>M</sub></b>  |   |
| 3 SEX<br><b>Female</b>  | 4 RACE<br><b>White</b> | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 25 24</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS.   |  | 7 UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                        | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.   |   |
| 10 CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6701 N. CHARLES ST. G.B.M.C.</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>----</b>  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                        |  |  |  |  |  |   |
| 13a STATE<br><b>Md.</b>   |                        | 13b COUNTY<br><b>Balto.</b>  |  | 13c CITY OR TOWN<br><b>Sparks</b>  |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Kresment</b>   |                        |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Wilhemina ---</b>  |  |  |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |                        | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>---</b>   |  | 17 INFORMANT ADDRESS<br><b>Mr. Francis J. Eilers, 15137 York Rd.</b>   |  |  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART 1 DEATH WAS CAUSED BY:<br><b>5570 IMMEDIATE CAUSE (a) RESPIRATORY FAILURE</b>   |                        |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>GENERALIZED PERITENONITIS</b>   |                        |  |  |  |  |  |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(c) <b>GANGRENOUS BOWEL</b>   |                        |  |  |  |  |  |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                        |  |  |  |  |  |   |
| 19a DATE OF OPERATION   |                        | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |
| 22a I certify that (I) (this hospital) attended the deceased from <b>9-8</b> <b>80</b> to <b>9-25</b> <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>9-25</b> <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |                        |  |  |  |  |  |   |
| 22b SIGNATURE<br><i>Alvaro Jerez</i>  |                        |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED<br><b>9/25/80</b>   |   |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ALVARO JEREZ</b>  |                        |  |  | 22c. ADDRESS<br><b>GBMC-6701 N. CHARLES ST.</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                        | 23b. DATE<br><b>9/27/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville, Maryland</b>  |   |
| 24. FUNERAL DIRECTOR<br><i>Martin D. Lawson</i>   |                        |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>SEP 29 1980</b>   |  |  |   |
| 24. ADDRESS<br><b>Martin D. Lawson, 10 W. Padonia Rd.</b>   |                        |  |  |  |  |  |   |

8 U S 2 1 1

2 22 40 15:00A

2 22 40 15:00A

TYNORE COUNTY

CHARLES ST. J. C. on 22nd

1315 York Road, York, Pa.

---

519-12-2748 A. J. and Mrs. E. J. York

RESPIRATORY FAILURE

GENERALIZED CONVULSIONS

CONVULSIONS BOWEL

30

2-22

80

2-22

80

2-22

519-12-2748 A. J. and Mrs. E. J. York

1315 York Road, York, Pa.

519-12-2748 A. J. and Mrs. E. J. York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |   |                                      |   |  | 8022131                                      |  |
|---|--|--|--|---|---|---|--------------------------------------|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |   |   |   |                                      |   |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>ELIZABETH C. ELLIOTT  |  |  |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>9 01 80   |   |                                      | 2b HOUR<br>1:45AM   |  |  |  |
| 3 SEX<br>FEMALE   |  | 4 RACE<br>WHITE  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>10 04 1900   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.                                   |                                      | 7 IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8 IF UNDER 24 HRS<br>HOURS MIN.              |  |
| 9a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 9b CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  | 10 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 11 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                |                                      |   |  |  |  |
| 12 CITY OR TOWN OF DEATH<br>TOWSON, MD.   |  | 13 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GBMC-6701 N. CHARLES ST. |  |   |   | 14 USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |                                      | 15 KIND OF BUSINESS OR INDUSTRY<br>Own Home   |  |  |  |
| 16 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>17a STATE Maryland 17b COUNTY Baltimore 17c CITY OR TOWN Cockeysville   |  |  |  |   | 18 INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 19 STREET ADDRESS<br>11100 Pool Road |   |  |  |  |
| 20 FATHER'S NAME<br>21a FIRST Joshua 21b MIDDLE Talbott 21c LAST Kelley   |  |  |  |   | 22 MOTHER'S MAIDEN NAME<br>23a FIRST May 23b MIDDLE Colgate 23c LAST Parks                    |   |                                      |   |  |  |  |
| 24 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 25 SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-66-6498   |  | 26 INFORMANT ADDRESS<br>Mrs Marie F. <del>XENNY</del> Belt, 11102 Pool Road   |   |   |                                      |   |  |  |  |
| 27 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MASSIVE CVA<br>436-<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |   |   |   |                                      |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 28 PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>PERENAL AZOTEMIA   |  |  |  |   |   |   |                                      |   |  |  |  |
| 29a DATE OF OPERATION   |  | 29b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 30a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>    |                                      | 30b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                     |  |  |  |
| 31a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 31b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 31c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |                                      |   |  |  |  |
| 32a INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 32b PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 32c LOCATION<br>STREET  |   | CITY OR TOWN  |                                      | COUNTY  |  | STATE  |  |
| 33 I certify that (I) (this hospital) attended the deceased from 8/29/80, 19, to 9/01/80, 19, that (I) (we) lost saw the deceased alive on 9/01, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.                                 |  |  |  |   |   |   |                                      |   |  |  |  |
| 34 SIGNATURE<br>Noel E. Taylor  |  |  |  | DEGREE<br>M.D.  |   |   |                                      | 35 ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 36 DATE SIGNED<br>9/01/80                    |  |
| 37 PHYSICIAN'S NAME (TYPE OR PRINT)<br>N. E. TAYLOR, MD.  |  |  |  | 38 ADDRESS<br>GBMC  |   |   |                                      |   |  |  |  |
| 39 BURIAL, CREMATION, REMOVAL<br>SPECIFY Burial   |  | 40 DATE<br>9-5-80  |  | 41 NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Mem. Gardens, Cockeysville, Balto. Md.   |   | 42 LOCATION<br>CITY OR TOWN   |                                      | COUNTY  |  | STATE  |  |
| 43 FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc. Towson, Md. 21204   |  |  |  | 44 ADDRESS<br>1050 Work Rd.   |   | 45 DATE REC'D. BY REGISTRAR<br>SEP 2 1980                                   |                                      | 46 REGISTRAR'S SIGNATURE<br>Dorothy Halbrudy  |  |  |  |

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CLINT

CLINT

10 10 1900

WHITE

WHITE

BALTIMORE COUNTY

TOWSON, MD. CHARLES ST.

MASSIVE

PERMANENT AZOTEMIA

XXV

9/10/80

X

OBNO

N. E. TAYLOR, MD.

SEP 2 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |  |   |  |   |   |   |  |  |  |  |
|---|--|---|---|---|--|---|--|---|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LOTTIE L. ENGLEHART</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>07</b> YEAR <b>80</b>   |   |  | 2b. HOUR<br><b>P. M.</b>  |  |   |   |   |  |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>                       |   | 5. DATE OF BIRTH<br>MONTH <b>07</b> DAY <b>28</b> YEAR <b>84</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>96</b> YRS.                                   |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>00</b> DAYS <b>00</b>                               |   | 8. IF UNDER 24 HRS.<br>HOURS <b>00</b> MIN. <b>00</b>   |  |  |  |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 10. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |   | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 12. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD                 |  |   |   |   |  |  |  |  |
| 13. CITY OR TOWN OF DEATH<br><b>ARBUTUS</b>   |  |   | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1025 CIRCLE DRIVE</b> |   |  | 15. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b> |  |   | 16. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>  |   |  |  |  |  |
| 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |   |  |   |  |   |   |   |  |  |  |  |
| 17a. STATE<br><b>MARYLAND</b>   |  |   | 17b. CITY OR TOWN<br><b>BALTIMORE</b>   |   |  | 17c. CITY OR TOWN<br><b>ARBUTUS</b>   |  |   | 17d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  | 17e. STREET ADDRESS<br><b>1025 CIRCLE DRIVE, 21227</b> |  |  |
| 18. FATHER'S NAME<br>FIRST <b>FRANK</b> MIDDLE <b>THARLE</b> LAST <b>THARLE</b>   |  |   |   | 19. MOTHER'S MAIDEN NAME<br>FIRST <b>CATHERINE</b> MIDDLE <b>RUSH</b> LAST <b>RUSH</b>  |  |   |  |   |   |   |  |  |  |  |
| 20. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  |   |   | 21. SOCIAL SECURITY NO.<br><b>218-12-0325</b>   |  |   |  | 22. INFORMANT<br><b>FLORENCE E. WURSTEN</b> ADDRESS<br><b>1025 CIRCLE DRIVE</b>     |   |   |  |  |  |  |
| 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1890</b> IMMEDIATE CAUSE (a) <b>Carcinoma Kidney</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>PSCVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <b>?</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Coronary artery disease.</b> |  |   |   |   |  |   |  |   |   |   |  |  |  |  |
| 24. DATE OF OPERATION<br><b>5/8/73</b>  |  |   |   | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Coronary artery disease.</b>  |  |   |  | 26. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |
| 28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |   | 29. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  |   |  | 30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |   |  |  |  |  |
| 31. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |   | 32. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   |  | 33. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |   |  |  |  |  |
| 34. I certify that (I) (this hospital) attended the deceased from <b>5/8/73</b> 19 <b>80</b> to <b>9/7/80</b> 19 <b>80</b> , that (I) <del>was</del> last saw the deceased alive on <b>9/7/80</b> 19 <b>80</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>and</del> <del>did</del> <del>not</del> view the body after death.  |  |   |   |   |  |   |  |   |   |   |  |  |  |  |
| 35. SIGNATURE<br><b>I. EARL PASS, M.D.</b>  |  |   |   | 36. DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 37. DATE SIGNED<br><b>9/9/80</b>  |   |   |  |  |  |  |
| 38. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>I. EARL PASS, M.D.</b>   |  |   |   | 39. ADDRESS<br><b>4001 WILKENS AVENUE, 21229</b>  |  |   |  |   |   |   |  |  |  |  |
| 40. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |   |   | 41. DATE<br><b>09-10-80</b>   |  | 42. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>                             |  | 43. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>         |   |   |  |  |  |  |
| 44. FUNERAL DIRECTOR NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>  |  |   |   | 45. ADDRESS<br><b>4107 WILKENS AVE.</b>   |  |   |  | 46. DATE REC'D. BY REGISTRAR<br><b>SEP 9 1980</b>                                   |   | 47. REGISTRAR'S SIGNATURE<br><b>Patricia Melroy</b>   |  |  |  |  |

9





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

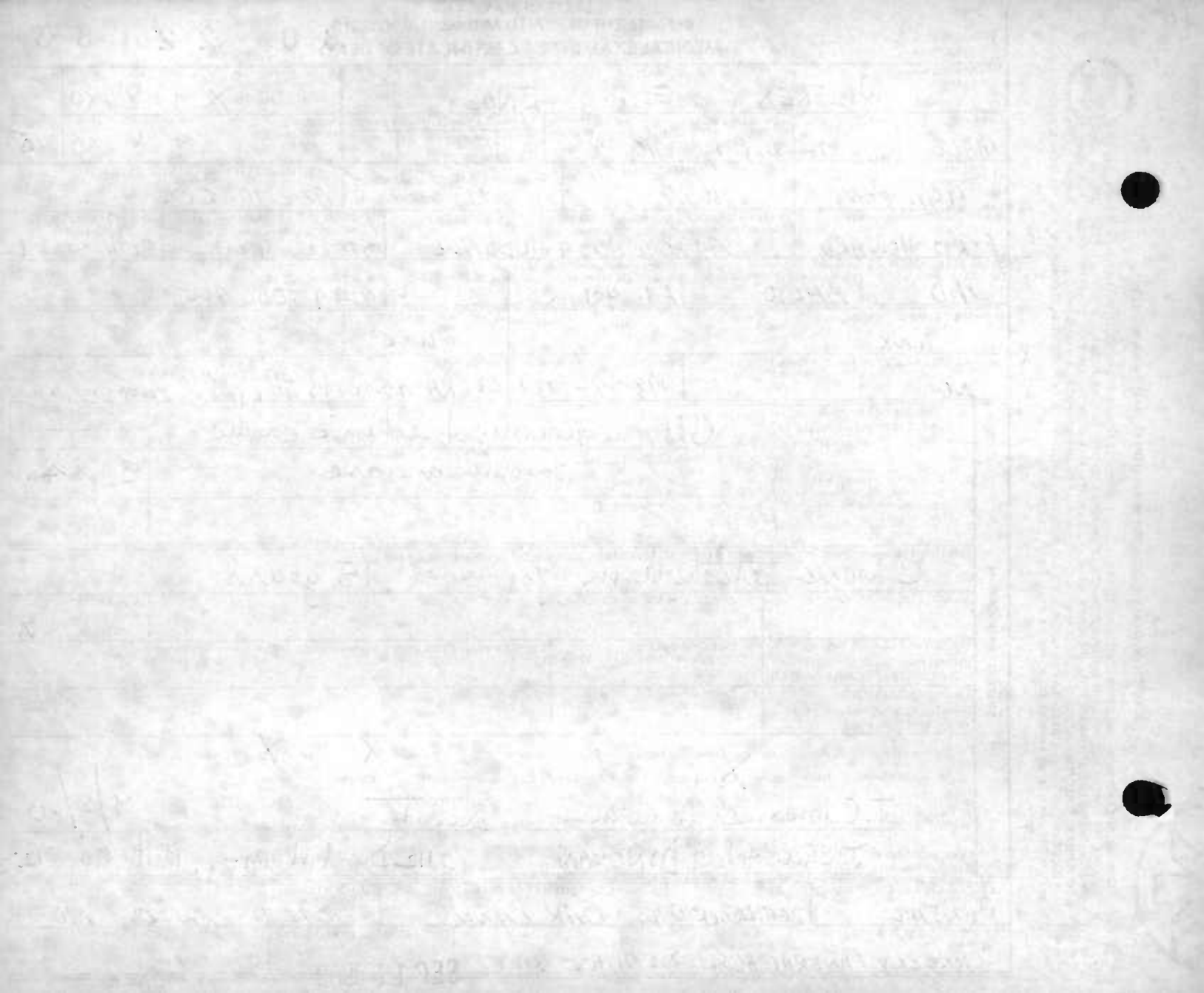
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FOR  
1- STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |                       |  |   |   |   |
|---|-----------------------|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>WILFRED E. ENOS  |                       |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>9 8 1980 |   | 2b. HOUR<br>M<br>2100   |
| 3 SEX<br>MALE   | 4 RACE<br>WHITE       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JUNE 13 1910   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>USA PENN.  |                       | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 10. CITY OR TOWN OF DEATH<br>FORT HOWARD  |                       | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>AT HOME 9204 TODDAVE |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BAL TO. CO. MD  |   |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>STEEL WORKER   |                       |  |   |   |   |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>BETH. STEEL  |                       |  |   |   |   |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                       |  |   |   |   |
| 13a. STATE<br>MD  | 13b. COUNTY<br>BALTO. | 13c. CITY OR TOWN<br>FT. HOWARD  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     | 13e. STREET ADDRESS<br>9204 TODDAVE   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNK   |                       |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNK  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) [IF YES, GIVE WAR OR DATES]<br>NO   |                       | 16b. SOCIAL SECURITY NO.<br>193-07-1737  |   | 17. INFORMANT<br>ADDRESS<br>810 N. KATROAD ST.<br>PORTAGE, PENN. 15946  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4392 Chronic generalized ischemic cardio -<br>DUE TO, OR AS A CONSEQUENCE OF vascular disease<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                       |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 yrs.                              |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br>Chronic alcoholism for over 15 years   |                       |  |   |   |   |
| 19a. DATE OF OPERATION  |                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                       | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                       |  |   |   |   |
| ACTUAL SIGNATURE<br>J. Crossan O'Donovan  |                       | TITLE (SPECIFY)<br>M.D. Deputy   |   | MEDICAL EXAMINER<br>DATE SIGNED<br>7/8/80   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>J. CROSSAN O'DONOVAN  |                       | ADDRESS<br>2112 Dunbarton Ave., Balt. Md. 21222  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY<br>BURIAL  |                       | 23b. DATE<br>SEPTEMBER 2, 1980   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>OAK LAWN  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>CONNELLY FUNERAL HOME   |                       | ADDRESS<br>300 MACE AVE  |   | 25a. DATE REC'D. BY REGISTRAR<br>SEP 15 1980  |   |
|   |                       |  |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |  |  |
| 1. FOR STATE REGISTRAR  |  |   |  |  | REG. NO.   |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |   |  |  | 2a. DATE OF DEATH  |  |  |  |  |
| FIRST MIDDLE LAST<br>Collier Epps   |  |   |  |  | MONTH DAY YEAR<br>9-28-80  |  |  |  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7b. HOUR   |  |
| M.  |  | B   |  | MONTH DAY YEAR<br>2-28-05  |  | 75 YRS.  |  | 10 <sup>12</sup> A.M.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?                            |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |
| S. C.   |  | U.S.A.  |  |  |  | BALTO. COUNTY. MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| REISTERSTOWN, MD.   |  | MT. WILSON ST. HOSP.                                    |  |  |  | LABORER.   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  | 13b. COUNTY  |  |  |  |  |
| BALTO.  |  |   |  |  | MD.  |  |  |  |  |
| 14. FATHER'S NAME   |  |   |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |
| UNKNOWN   |  |   |  |  | VICTORIA EPPS.   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)   |  |   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |  |
| NO  |  |   |  |  | 249-12-0120  |  | 831 N. CAROLINE STREET.                                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Arrest</u><br><u>4148</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Old Myocardial Infarct</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ASCVD and Generalized Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Pulmonary Tuberculosis Class III - Peripheral Artery Insufficiency legs</u>   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-15-</u> 19 <u>80</u> , to <u>9-28-</u> 19 <u>80</u> , that <u>(I)</u> (we) lost saw the deceased alive on <u>9-28-</u> 19 <u>80</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>ESAR VALLE CAVERO M.D.</u>   |  |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br>9-28-80                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ESAR VALLE CAVERO  |  |   |  |  | 22e. ADDRESS<br>Mount Wilson Center  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |   | 23b. DATE<br>10-5-80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>church cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>newberry, S.C. |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WHI.c.march 1101 E. NORTH AVE.  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 1 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Ricky McBrady</u>           |  |  |

MEDICAL CERTIFICATION



TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 365-5633.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 80 22135   |  |   |  |
|---|--|---|--|--|--|---|--|
| FOR<br>STATE<br>REGISTRAR   |  |   |  | REG. NO.   |  |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Baby Boy Erdman   |  |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>7 8 80   |  |   |  |
| 3 SEX<br>Male   |  |   |  | 2b HOUR<br>12 P M  |  |   |  |
| 4 RACE<br>Cau.  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>7 8 80   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br>1 8  |  | 7b HOUR<br>12 P M   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |
| 10 CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Greater Baltimore Medical Center |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |
| 13a STATE<br>Md   |  |   |  | 13b COUNTY<br>Balt   |  | 13c CITY OR TOWN<br>Joppatowne  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert Luther Erdman   |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Carole Jean Kroll  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |  | 16b SOCIAL SECURITY NO   |  | 17 INFORMANT ADDRESS<br>mother  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Severe Immaturity<br>7651<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from 7/8, 19 80, to 7/8, 19 80, that (I) (we) lost<br>saw the deceased alive on 7/8, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                    |  |   |  |  |  |   |  |
| 22b SIGNATURE<br>V. Torres  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c DATE SIGNED<br>7/8/80   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>V. Torres   |  |   |  | 22e ADDRESS<br>6701 N. Charles St. 21204   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>cremation  |  | 23b DATE<br>7-10-80   |  | 23c NAME OF CEMETERY OR CREMATORY<br>GBMC  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Towson Balto MD  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Charles S. S. S.   |  |   |  | 25a DATE RECEIVED BY REGISTRAR<br>OCT 2 1980   |  | 25b RECEIVED BY REGISTRAR<br>[Signature]  |  |
| 26 ADDRESS<br>6701 N. Charles St.   |  |   |  | 27   |  |   |  |

SS 8

(M)

SS 8



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |                  |  |  |   |  |   |                    | REG. NO. 8 0 2 2 1 3 6 |  |   |  |   |  |   |  |               |  |                    |  |
|--|--|------------------|------------------|--|--|---|--|---|--------------------|------------------------|--|---|--|---|--|---|--|---------------|--|--------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  | FIRST<br>William |  |  | MIDDLE<br>B.                                  |  |   | LAST<br>Fazenbaker |                        |  | 2a. DATE OF DEATH<br>KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> |  | MONTH<br>9  |  | DAY<br>26   |  | YEAR<br>19 80 |  | 2b. HOUR<br>a 2:55 |  |
| 3. SEX<br>male   |  | 4. RACE<br>white |                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 11, 1959  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>20 YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |                    | IF UNDER 24 HRS.       |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>9 26 19 80  |  | 24. HOUR<br>a 2:55  |  |   |  |               |  |                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |                  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                    |                        |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore Co. MD  |  |   |  |   |  |               |  |                    |  |
| 10. CITY OR TOWN OF DEATH<br>Essex   |  |                  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Old Eastern Ave. at Weber Ave. |  |   |  |   |                    |                        |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Labor                            |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction |  |               |  |                    |  |
| 13a. STATE<br>Maryland   |  |                  |                  | 13b. COUNTY<br>Baltimore   |  |   |  | 13c. CITY OR TOWN<br>Middle River   |                    |                        |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br>3627 Dahlia Lane 21220                                       |  |   |  |               |  |                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Vernon Bernard - Fazenbaker  |  |                  |                  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rosalie - Dobbins  |                    |                        |  |   |  |   |  |   |  |               |  |                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                  |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-   |  |   |  | 17. INFORMANT<br>ADDRESS<br>Rosalie Fazenbaker, mother Same   |                    |                        |  |   |  |   |  |   |  |               |  |                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Craneo-cerebral trauma</u><br>8151<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |                  |                  |  |  |   |  |   |                    |                        |  |   |  |   |  |   |  |               |  |                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |                  |                  |  |  |   |  |   |                    |                        |  |   |  |   |  |   |  |               |  |                    |  |
| 19a. DATE OF OPERATION   |  |                  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |                    |                        |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |               |  |                    |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>2:08xx 9-26- 19 80  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Passenger in auto/fixed object collision.                                  |                    |                        |  |   |  |   |  |   |  |               |  |                    |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>road  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Weber Ave. Old Eastern Ave. at Essex Balto. Md.  |                    |                        |  |   |  |   |  |   |  |               |  |                    |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |                  |  |  |   |  |   |                    |                        |  |   |  |   |  |   |  |               |  |                    |  |
| ACTUAL SIGNATURE<br><u>Virginia L Dolan</u>  |  |                  |                  | TITLE (SPECIFY)<br>M.D. Assistant  |  |   |  |   |                    |                        |  |   |  | DATE SIGNED<br>9-26-80  |  |   |  |               |  |                    |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Virginia L. Dolan, M.D.  |  |                  |                  | ADDRESS<br>111 Penn St.  |  |   |  |   |                    |                        |  |   |  |   |  |   |  |               |  |                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                  |                  | 23b. DATE<br>9-29-80   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery   |                    |                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore County, Maryland                          |  |   |  |   |  |               |  |                    |  |
| 24. FUNERAL DIRECTOR<br><u>Brudzinski Funeral Home PA 1407 Old Eastern Ave.</u>  |  |                  |                  |  |  |   |  |   |                    |                        |  |   |  |   |  |   |  |               |  |                    |  |
| 25a. DATE REC'D. BY REGISTRAR<br>SEP 30 1980   |  |                  |                  |  |  |   |  |   |                    |                        |  |   |  |   |  |   |  |               |  |                    |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |                  |                  |  |  |   |  |   |                    |                        |  |   |  |   |  |   |  |               |  |                    |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |   |  |              |   |  | 8 0 2 2 1 3 7  |  |  |  |
|--|--|--|---|--|---|--|--------------|---|--|--|--|--|--|
| FOR<br>1 - STATE<br>REGISTRAR  |  |  | REG. NO.  |  |   |  |              |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST<br>John   |  | MIDDLE<br>H.  |  | LAST<br>Fell |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>September 18, 1980                               |  |  | 2b. HOUR<br>8:36a M                                |  |
| 3 SEX<br>MALE  |  |  | 4 RACE<br>WHITE   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>AUGUST 9, 1906     |  |              | 6 AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.   |  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTIMORE MD.   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |              |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                          |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>ROSSVILLE  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQUARE HOSPITAL |  |   |  |              |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br>OFFICE SUPERVISOR |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>BASKIN ROBINS |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND  |  |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTIMORE                          |  |              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3322 CARDENAS AVENUE 21213  |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>HENRY A. FELL   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNIE ROSEMER  |  |   |  |              |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218 32 6504A   |  |   | 17 INFORMANT ADDRESS<br>JEANETTE M. FELL 3322 CARDENAS AVE. BALTO. MD.   |              |   |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cardiac Electromechanical Dissociation</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(c) <u>Probable Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF |  |  |   |  |   |  |              |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):   |  |  |   |  |   |  |              |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  |              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |              |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |              |   |  |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <u>September 16, 1980</u> , to <u>September 18, 1980</u> , that (we) last saw the deceased alive on <u>September 18, 1980</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.   |  |  |   |  |   |  |              |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Samuel Westrick</i>   |  |  |   |  |   | DEGREE<br>M.D.   |              |   | 22c. DATE SIGNED<br>9/18/80  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Samuel Westrick, M.D.   |  |  |   |  |   | 22e. ADDRESS<br>9000 Franklin Square Drive 21237   |              |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |  | 23b. DATE<br>SEPT. 20, 80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>PARKWOOD CEMETERY |  |              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>PARKVILLE BALTIMORE MARYLAND                      |  |  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>THE DIPPEL BROTHERS INC. 7110 BELAIR RD. MARYLAND   |  |  |   |  |   | ADDRESS<br>BALTIMORE   |              | 25. DATE REC'D. BY REGISTRAR<br>SEP 19 1980   |  | 26. REGISTRAR'S SIGNATURE<br><i>Robert M. Kelly</i>  |  |  |  |



NAME

WILLIAM

WILLIAM D. 1906

70

WILLIAM D. 1906

U.S.A.

ROBERTSON

FRANKLIN SQUARE HOSPITAL

OFFICE SUPERVISOR WASHINGTON

RYLAND

BALTIMORE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 0 2 2 1 3 8   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Anthony Scott FELLON</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 4, 1980</b>   |  | 2b. HOUR<br>MIN.<br><b>6:52pm</b>  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 4 80</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>1 32</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. CITY OR TOWN<br><b>Harford</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>1213 Hanson Road, Lot 37</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Gregory Paul Fellon</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Linda Jane Wertz</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br><b>Linda Fellon 1213 Hanson Rd. Lot 37(mother)</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>7689 Cardio-pulmonary Arrest</b><br>IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypoxia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Prematurity</b>  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 4, 19 80</b> , to <b>September 4, 19 80</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>September 4, 19 80</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>S. J. Wertz</i>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>9/4/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Steven Wiak, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr., Balto., Md. 21237</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Disposal</b>  |  | 23b. DATE<br><b>9/8/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Franklin Square Hosp.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>NONE</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 24 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Peter H. Reed</i>   |  |

8 7 1 5 1 0 8

11 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

23  
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

22139

REG. NO.

|  |  |   |  |   |   |   |   |  |  |
|--|--|---|--|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOSEPHINE C. FERLITA</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 20, 1980</b>       |   |   | 2b. HOUR<br>M   |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 4, 1904</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Georgia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph's Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Counselor</b>            |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |   |   |   |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Towson</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>706 Saylor Court</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph A. Cerniglia</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rose Cefalu</b> |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>259-26-0566</b>                         |   | 17. INFORMANT ADDRESS<br><b>Mrs. Marianna R. Fava same as # 13</b>  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>410-</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Instant</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 19 70</b> to <b>Sept 19 80</b> , that (I) (we) last saw the deceased alive on <b>Sept 20 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Robert J. Lyden M.D.</b>  |  |   |  |   |   | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>9/22/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert J. Lyden M.D.</b>   |  |   |  |   |   | 22e. ADDRESS<br><b>6402 Golden Ring Road</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>9/23/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Cem.</b>    |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. 1050 York Road</b>   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 24 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Robert J. Lyden</b>   |  |



Robert

Mr. J. Edgar Hoover  
Washington, D. C.

Mr. J. Edgar Hoover  
Washington, D. C.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 0 2 2 1 4 0  |  |   |  |   |  |   |  |
|---|--|---|--|--|--|---|--|---|--|---|--|
| FOR<br>STATE<br>REGISTRAR   |  |   |  | REG. NO.   |  |   |  |   |  |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a DATE OF DEATH   |  |   |  | 7b HOUR   |  |   |  |
| EDITH FINKELMAN   |  |   |  | SEPT. 30, 1980   |  |   |  | 4:07 A.M.   |  |   |  |
| 3 SEX   |  | 4 RACE  |  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS   |  |
| FEMALE  |  | WHITE   |  | FEB. 2, 1912   |  | 68 YRS.   |  | MONTHS DAYS   |  | HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |   |  |   |  |
| PENNA.  |  | USA   |  |  |  | BALTIMORE COUNTY MD.  |  |   |  |   |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |   |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b KIND OF BUSINESS OR INDUSTRY                              |  |
| PIKESVILLE  |  | 22 WARREN PARK DR. APT. B-3 (21208)   |  |  |  |   |  | HOUSEWIFE   |  | HOME  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13d INSIDE CITY LIMITS?  |  |   |  | 13e STREET ADDRESS  |  |   |  |
| 13a STATE   |  | 13b COUNTY  |  | 13c CITY OR TOWN   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 22 WARREN PARK DR. APT. B-3 (21208)   |  |   |  |
| MARYLAND  |  | BALTIMORE   |  | PIKESVILLE   |  |   |  |   |  |   |  |
| 14 FATHER'S NAME  |  |   |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |   |  |
| FIRST   |  | MIDDLE  |  | LAST   |  | FIRST   |  | MIDDLE  |  | LAST  |  |
| JOSEPH  |  |   |  | MAYER  |  | CAREY   |  |   |  | UNKNOWN   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |  | 16b SOCIAL SECURITY NO.  |  | 17 INFORMANT ADDRESS  |  |   |  |   |  |
| NO  |  |   |  | 220-48-7946  |  | CARY A. FINKELMAN 22 WARREN PARK DR. (21208)                        |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |  |  |   |  |   |  |   |  |
| PART I. DEATH WAS CAUSED BY   |  |   |  |  |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (a) <i>Disseminated Cancer of Colon</i>   |  |   |  |  |  |   |  |   |  |   |  |
| 1539 DUE TO, OR AS A CONSEQUENCE OF <i>and many</i>   |  |   |  |  |  |   |  |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |  |  |   |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |  |   |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |  |  |   |  |   |  |   |  |
| 19a DATE OF OPERATION   |  |   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a AUTOPSY?  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |   |  |  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <i>9/28</i> 19 <i>80</i> to <i>9/30</i> 19 <i>80</i> , that (I) (we) saw the deceased alive on <i>9/28</i> 19 <i>80</i> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |   |  |   |  |
| 22b SIGNATURE   |  |   |  | DEGREE   |  |   |  | 22c DATE SIGNED   |  |   |  |
| <i>Stanley M. Rosen</i>   |  |   |  |  |  |   |  | 9/30/80   |  |   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e ADDRESS  |  |   |  |   |  |   |  |
| STANLEY ROSEN   |  |   |  |  |  |   |  |   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL  |  |   |  | 23b DATE   |  | 23c NAME OF CEMETERY OR CREMATORY                                   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE                                     |  |   |  |
| BURIAL  |  |   |  | 10/1/80  |  | BETH YEHUDA ANSHE KURLAND   |  | BALTIMORE, MD.  |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME   |  |   |  | 25a DATE REC'D. BY REGISTRAR   |  |   |  | 25b REGISTRAR'S SIGNATURE   |  |   |  |
| SOL LEVINSON & BROS.  |  |   |  | 6010 RISTERSTOWN RD.<br>BALTIMORE, MD. (21215)   |  |   |  | OCT 2 1980 <i>Patricia McCreedy</i>   |  |   |  |





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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |  |   |  |   |  |                |   |  |
|--|--|---|---|--|---|--|---|--|----------------|---|--|
| 1- FOR STATE REGISTRAR   |  |   |   |  |   |  |   |  |                |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>THOMAS RICHARD FITZELL   |  |   |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>SEPT. 17 1980   |  |   |  |                | 2b. HOUR<br>10:00P  |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |   | 5 DATE OF BIRTH MONTH DAY YEAR<br>May 11, 1911   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |                | IF UNDER 24 HRS<br>HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                          |   |  |                |   |  |
| 10 CITY OR TOWN OF DEATH<br>TOWSON   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SAINT JOSEPH HOSPITAL |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Broker              |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Real Estate   |                |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |  |   |  |   |  |                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Timonium  |   | 13e. STREET ADDRESS<br>208 Charmouth Rd.   |   |  |                |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Richard Fitzell  |  |   |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Emma Lynch  |  |   |  |                |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |  |   | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>WW II |  | 17 INFORMANT<br>Mrs. Dorothy R. Fitzell   |  |   | ADDRESS<br>Same  |                |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>BLEEDING PEPTIC ULCER</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>BLEEDING STRESS ULCER - HEPATIC FAILURE SECONDARY TO POST NECROTIC CIRRHOSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |  |   |  |   |  |                |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |   |  |   |  |                |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |  |                |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |                |   |  |
| 22a. I certify that (this hospital) attended the deceased from <u>SEPT. 2</u> , 19 <u>80</u> , to <u>SEPT. 17</u> , 19 <u>80</u> , that (we) lost saw the deceased alive on <u>SEPT. 17</u> , 19 <u>80</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.   |  |   |   |  |   |  |   |  |                |   |  |
| 22b. SIGNATURE<br>PEMY CHHIM   |  |   |   |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED   |                |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PEMY CHHIM  |  |   |   |  | 22e. ADDRESS<br>7620 YORK RD. TOWSON, MD. 21204   |  |   |  |                |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Entombment  |  | 23b. DATE<br>Sept. 20, 1980   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Cockeysville Balt. Co. Md.                |   |  |                |   |  |
| 24 FUNERAL DIRECTOR NAME<br>Mitchell-Wiedefeld Home, Inc.  |  |   |   |  | ADDRESS<br>6500 York Rd. Balto., Md.  |  | 25a. DATE REC'D BY REGISTRAR<br>SEP 22 1980 |  | 25b. SIGNATURE |   |  |

24

1987

089 3 3 532

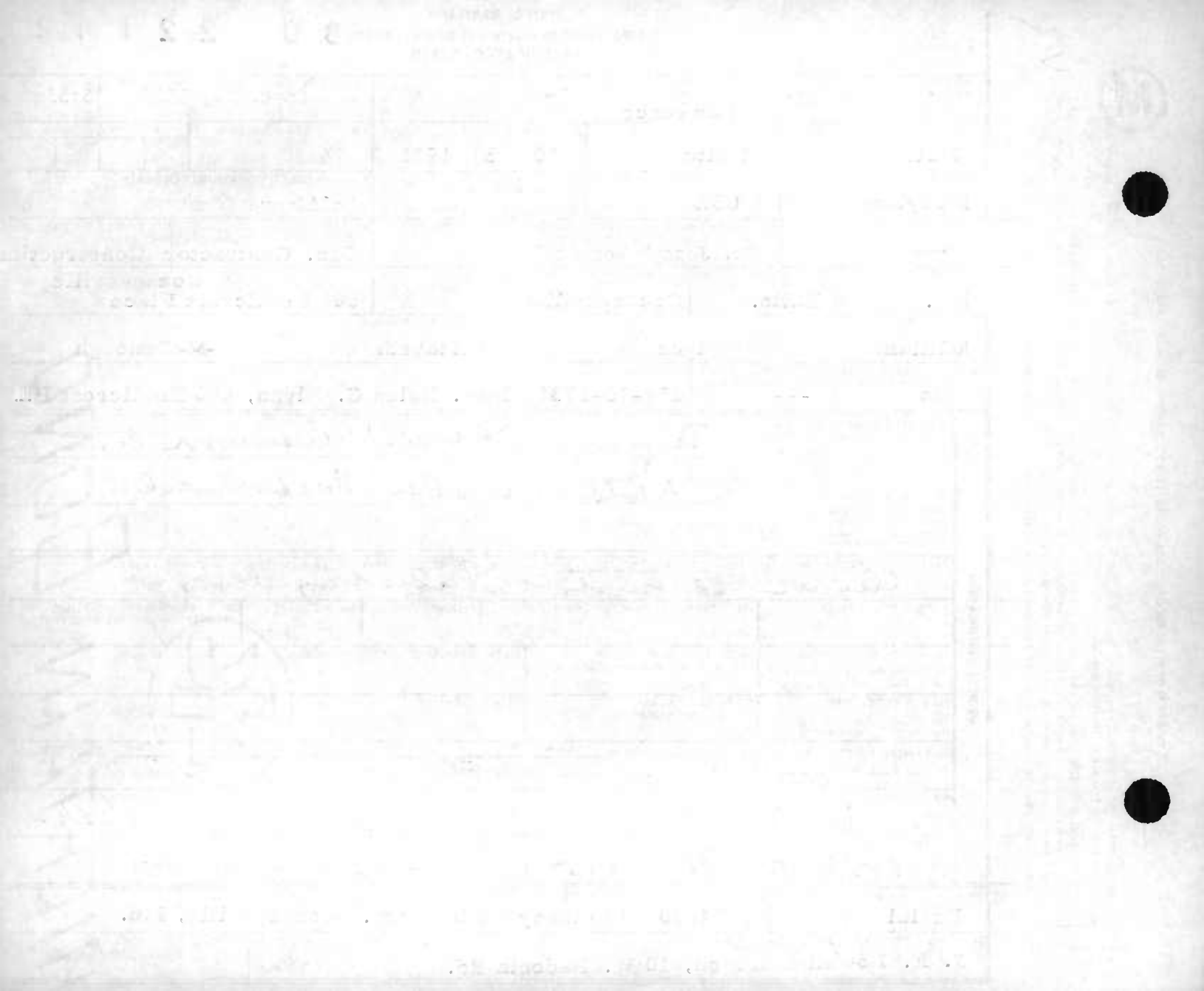


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |  |  |  |   | 8 0 2 2 1 4 2  |  |
|---|--|--|--|---|--|--|--|--|---|--|--|
| 1- FOR STATE REGISTRAR  |  |  |  |   |  |  |  |  |   | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>William L. Flynn   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>Sept. 22, 1980   |  |  | 2b. HOUR<br>3:55a   |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>10 31 1905   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |   | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD  |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Gen. Contractor  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction                                    |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  |  |  |   |  | 13b. COUNTY<br>Balto.  |  | 13c. CITY OR TOWN<br>Cockeysville  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William Flynn  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Elizabeth -McDonough   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No ---  |  |  |  | 16b. SOCIAL SECURITY NO.<br>214-16-6731   |  | 17. INFORMANT ADDRESS<br>Mrs. Helen C. Flynn, 606 Knollcrest Pl.   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ruptured abdominal aneurysm</u><br>4413<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Arteriosclerotic cardiovascular</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Chronic obstructive pulmonary disease</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Chronic obstructive pulmonary disease</u> |  |  |  |   |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Sept. 20,</u> 19 <u>80</u> , to <u>Sept. 22,</u> 19 <u>80</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Sept. 22,</u> 19 <u>80</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.  |  |  |  |   |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><u>Frank V. Patterson, M.D.</u>   |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>9/22/80  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>FRANK V. PATTERSON   |  |  |  |   |  | 22e. ADDRESS<br>7620 York Rd. Towson, Md. 21204  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial   |  |  |  | 23b. DATE<br>9/24/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Cem.  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cockeysville, Md. |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>J. E. Lowell Lemmon, 10 W. Padonia Rd.  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 25 1980   |  | 25b. REGISTRAR'S SIGNATURE<br><u>History McBrady</u>                                 |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | REG. NO. 80 22143                            |  |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR   |  | 2b. HOUR                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Patricia Mary FOOTE  |  |  |  |   |  | September 2, 1980   |  |  |  | 5:10PM                                       |  |
| 3. SEX<br>M Female  |  | 4. RACE<br>W   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 18 35   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>45 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN                 |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MO  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                                     |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>ESSEX  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQ. HOSP |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HSWE                        |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>MO BALTO ESSEX  |  |  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>521 RIVERSIDE DR.   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GEORGE J. METZGER   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MADELINE CARBACK                               |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  | 17. INFORMANT<br>ZACHARIAH FOOTE  |  |   |  | ADDRESS<br>ABOVE   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 7454 Ventricular fibrillation<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Congestive Heart Failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Eisenmenger's Syndrome                            |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from August 29, 1980, to September 2, 1980, that I (we) last saw the deceased alive on September 2, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death. |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>P. Befanis  |  |  |  | DEGREE  |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>9/2/80                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Paul Befanis   |  |  |  | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>9/5/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLLY HILL  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Connelly F.H.   |  |  |  | ADDRESS<br>300 MACE AVE   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 8 1980  |  | 25b. REGISTRAR'S SIGNATURE                   |  |



SEP 8 1960





FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARY FRANCES FORDER</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09-03-1980</b>                             |   | 2b. HOUR<br><b>6:58 P.M.</b>   |
| 3 SEX<br><b>FEMALE</b>   | 4 RACE<br><b>White</b>   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2-23-1896</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD                               |  |
| 10 CITY OR TOWN OF DEATH<br><b>Randallstown</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Randallstown Convalescent Center</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Halethorpe</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>5631 OAKLAND Rd 21227</b>  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John H. Winter</b>   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Alice G. Brokaw</b>               |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-74-9135</b>  |  | 17. INFORMANT<br><b>Mr. Ralph Waldo Forder</b><br><b>5631 Oakland Rd., Baltimore, MD 21227</b>  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC CA. OF STOMACH</b><br><b>1519</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 months</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>AUG. 1980</b> to <b>SEPT. 3 1980</b> , that (I) (we) last saw the deceased alive on <b>Sept. 3 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                     |  |  |  |   |  |
| 22b. SIGNATURE<br><b>B. Matos M.D.</b>   |  |  |  | 22c. DATE SIGNED<br><b>9/4/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. MATOS M.D.</b>  |  | 22e. ADDRESS<br><b>21 CRANBROOK Rd. COCKEYSVILLE MD. 21030</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>9/6/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Winters Church Cem.</b>                                |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>New Windsor Carroll MD</b>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Loring Byers Funeral Directors, P.A.<br/>8728 Liberty Rd., Randallstown, MD 21133</b>                           |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>SEP. 5 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



*[Faint, mostly illegible handwritten text covering the majority of the page. Some words like 'to', 'the', 'and' are visible.]*



FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 1 4 5

REG. NO.

|   |  |   |   |  |                                  |  |   |   |  |  |
|---|--|---|---|--|----------------------------------|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Harry Audwin FRANCIS   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>September 9, 1980          |  |                                  | 2b. HOUR<br>5:51 AM  |   |   |  |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>12 30 22  |                                  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |   |   |  |  |
| 10 CITY OR TOWN OF DEATH<br>Rossville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |   |  |                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Refrigeration Oper.-U.S.Gov.   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |   | 13b. CITY<br>Baltimore  |  | 13c. CITY OR TOWN<br>White Marsh |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br>10916 Philadelphia Road |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harry V Francis  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Myrtle M. Proctor |  |                                  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II  |   | 17 INFORMANT<br>ADDRESS<br>M. Catherine Francis 10916 Philadelphia   |                                  |  |   |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u><br><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |   |  |                                  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |   |  |                                  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |                                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                  |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                  |  |   |   |  |  |
| 22a. I certify that (this hospital) attended the deceased from <u>September 7</u> , 19 <u>80</u> , to <u>September 9</u> , 19 <u>80</u> , that (we) last saw the deceased alive on <u>September 9</u> , 19 <u>80</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) did <del>not</del> view the body after death. |  |   |   |  |                                  |  |   |   |  |  |
| 22b. SIGNATURE<br><u>Paul J. Befanis</u>  |  |   |   | DEGREE   |                                  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>9/9/80  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Paul Befanis M.D.  |  |   |   | 22e. ADDRESS<br>9000 Franklin Square Drive 21237   |                                  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>9/11/80  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith   |                                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Overlea Baltimore Md.  |   |   |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Lassahn F.H.   |  |   |   | ADDRESS<br>7401 Belair Rd  |                                  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 15 1980   |   |   |  |  |
|   |  |   |   |  |                                  | 25b. REGISTRAR'S SIGNATURE<br>L. J. McCreedy   |   |   |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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9



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

8 0

2 2 1 4 6

## CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DOROTHY E. GAILEY   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>September 2, 1980                      |  | 2b. HOUR<br>6:44 P.M.  |
| 3 SEX<br>Female  | 4 RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 3, 1912  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS.                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Balto. Co. Md.  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore Co. MD.                      |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Balto. Co. Gen. Hospt. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>Md.  |   |   | 13b. CITY OR TOWN<br>Balto.   | 13c. STREET ADDRESS<br>15296 Dover Road  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edmund Williams  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Parks  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-26-5857  |   | 17. INFORMANT ADDRESS<br>Mr. John L. Gailey Reisterstown, Md.                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Death massive myocardial infarct</u><br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c) |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                            |   |   |   |  |  |
| 22b. SIGNATURE<br><u>Milton Behlen</u>   |   | DEGREE<br>MO  |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Milton Behlen   |   | 22e. ADDRESS<br>11969 Reisterstown Rd. 21136  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial  |   | 23b. DATE<br>Sept. 5, 1980  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Lake View Memorial                       |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Sykesville, Md.  |   | 23e. DATE REC'D. BY REGISTRAR<br>SEP 5 1980   |   | 23f. REGISTRAR'S SIGNATURE<br><u>Jeffrey H. [Signature]</u>                    |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Eline Funeral Home Reisterstown, Md. 21136   |   |   |   |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



|             |             |             |             |             |
|-------------|-------------|-------------|-------------|-------------|
| <p>1900</p> | <p>1901</p> | <p>1902</p> | <p>1903</p> | <p>1904</p> |
| <p>1905</p> | <p>1906</p> | <p>1907</p> | <p>1908</p> | <p>1909</p> |
| <p>1910</p> | <p>1911</p> | <p>1912</p> | <p>1913</p> | <p>1914</p> |
| <p>1915</p> | <p>1916</p> | <p>1917</p> | <p>1918</p> | <p>1919</p> |
| <p>1920</p> | <p>1921</p> | <p>1922</p> | <p>1923</p> | <p>1924</p> |
| <p>1925</p> | <p>1926</p> | <p>1927</p> | <p>1928</p> | <p>1929</p> |
| <p>1930</p> | <p>1931</p> | <p>1932</p> | <p>1933</p> | <p>1934</p> |
| <p>1935</p> | <p>1936</p> | <p>1937</p> | <p>1938</p> | <p>1939</p> |
| <p>1940</p> | <p>1941</p> | <p>1942</p> | <p>1943</p> | <p>1944</p> |
| <p>1945</p> | <p>1946</p> | <p>1947</p> | <p>1948</p> | <p>1949</p> |

*Handwritten signature or mark at the bottom left.*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |  |  |   |  | 8 0 2 2 1 4 7  |  |
|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  | CERTIFICATE OF DEATH  |  |  |  |   |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ann Louise Gardner  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9 2 80   |  |  |  | 2b. HOUR<br>6 P M   |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 2 1894  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 74 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                    |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Little Sisters of the Poor |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br>Maryland   |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>321 W. Pine Street  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Patrick McKeon   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Ellen Sheehan   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |   |  | 16b. SOCIAL SECURITY NO.<br>096 10 3572   |  | 17. INFORMANT ADDRESS<br>Rev. George Gardner 6420 E. Pratt St.                 |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>C.A. of cervix &amp; C.U.A.</u><br>1809<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>H.S. Cardiovascular disease</u><br>(c) <u>Dis. B. &amp; T. &amp; Cardiovascular</u> |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6</u> , 19 <u>70</u> , to <u>9.2</u> , 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>9.2</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.        |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Stanley Ankudis</u>   |  |   |  | DEGREE<br>MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>     |  |  |  | 22c. DATE SIGNED<br>9.3.80  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>STANLEY ANKUDIS   |  |   |  | 22e. ADDRESS<br>1101 Maiden Choice La. Baltimore  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>9/6/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St Anthony's  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Lancaster Pa                                      |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Walter Dabrowski   |  |   |  | ADDRESS<br>1005 Dundalk Avenue  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 4 1980   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Stanley Ankudis</u>   |  |



0921 1932



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   | 8 0 2 2 1 4 8  |   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>George Edward Geyer  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>Sept. 24, 1980                             |   |  | 2b. HOUR<br>7:12a M  |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>August 16, 1908   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore county MD.                        |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sheet Metal Worker |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Fuel  |  |  |  |
| 13a. STATE<br>Maryland   |  |   |  |   | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |
| 14. FATHER'S NAME<br>George S. Geyer   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>Gertrude M. Byrnes                                 |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes.  |  |   |  |   | 16b. SOCIAL SECURITY NO.<br>WW II 219-07-3528                                  |   | 17. INFORMANT<br>Katherine N. Geyer  |  |  | ADDRESS<br>Same                              |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY: <u>Carcinoma of liver with metastases</u><br>IMMEDIATE CAUSE (a) <u>1552</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Sept. 3,</u> 19 <u>80</u> , to <u>Sept. 24,</u> 19 <u>80</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>Sept. 24,</u> 19 <u>80</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death) |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Lester A. Hall</i>  |  |   |  |   | DEGREE<br>M.D.   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>Sept. 24, 1980           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Lester Wall, M.D.   |  |   |  |   | 22e. ADDRESS<br>7620 York Rd. Towson, Md. 21204                                |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   | 23b. DATE<br>Sept. 26, 1980  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore                                |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City, Maryland               |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Mitchell-Wiedefeld Home, Inc.   |  |   | ADDRESS<br>6500 York Rd. Baltimore, Md.                                |   | 25. DATE RECEIVED BY REGISTRAR<br>SEP 29 1980                                  |   | 25b. DEPT. OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 0 2 2 1 4 9   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Thomas J. Gillooly</b><br><i>THOMAS- GILLOOLY</i>   |  |  |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
|   |  |  |  | MONTH DAY YEAR<br><b>9 21 80</b>  |  | 2:40 <sup>A</sup> M  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 11, 1906</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Spring Grove State Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer (Patient)</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Mental Hosp.</b>   |  |
| 13a. STATE <b>Maryland</b> 13b. CITY OR TOWN <b>Baltimore</b> 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 13d. STREET ADDRESS<br><b>Spring Grove State Hospital</b>   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>James F. Gillooly</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Anna McAvoy</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217-58-1788</b>   |  | 17. INFORMANT ADDRESS<br><b>Mr. &amp; Mrs. Hubert F. Tierney-1102 E. Lanvale St.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RENAL FAILURE</b><br><b>5990</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>NEPHROSCLEROSIS.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>URINARY TRACT INFECTION</b>               |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Blomatt Prabhakar, MD</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>9-21-80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BHARATHI PRABHAKAR.</b>   |  |  |  | 22e. ADDRESS<br><b>SPRING GROVE HOSPITAL CENTER</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Sept. 25, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>H. Sander &amp; Sons, Inc., Baltimore, Md.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 29 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert M. Brady</i>   |  |

INDUSTRIAL REVOLUTION

REVOLUTION

INDUSTRIAL

INDUSTRIAL

INDUSTRIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

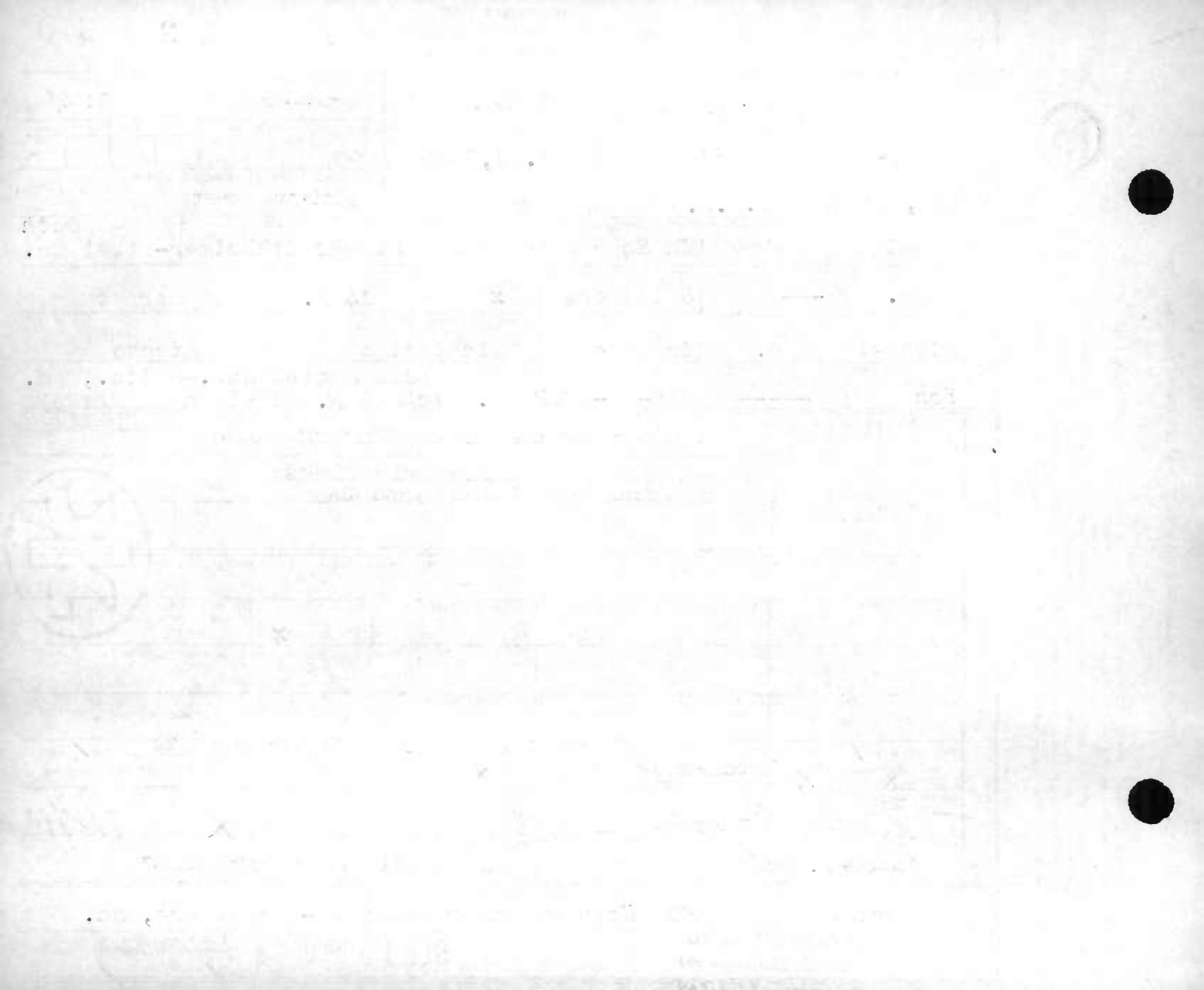
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 0 2 2 1 5 0  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GUISEPPI (Joseph) GIROLAMO</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 8, 1980</b>  |  | 2b. HOUR<br><b>1:25p</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 21, 1889</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Vasto, Italy</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>        |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rosedale</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Blacksmith</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel Co.</b>  |  |
| 13a. STATE<br><b>Md.</b>  |  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Michael D. Girolamo</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Clemintina Micon</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>216-10-1292</b>   |  | 17. INFORMANT<br><b>Mr. Michael P. Girolamo</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4292 Cardio-respiratory Arrest; Arteriosclerotic</b><br>IMMEDIATE CAUSE (a) <b>Cardiovascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <b>Abdominal Pain of unknown etiology</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)       |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 5, 1980</b> , to <b>September 8, 1980</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>September 8, 1980</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Hattie M. Faison</b>   |  |  |  | DEGREE<br><b>MD.</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>9/8/80</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  |  | 23b. DATE<br><b>9/11/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cemetery - Baltimore, Md.</b>                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John A. Moran, Inc.</b>  |  |  |  | 25. DATE RECEIVED BY REGISTRAR<br><b>SEP 15 1980</b>   |  |  |  |
| ADDRESS<br><b>3000 E. Baltimore St.</b>   |  |  |  | REGISTRAR'S SIGNATURE<br><b>Anthony McElroy</b>  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 8022151  |  | REG. NO.  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>CHARLES H GLASS</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>19</b> YEAR <b>80</b> |   |  | 2b. HOUR<br><b>1:00 PM</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>28</b> YEAR <b>20</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS  |  | 7. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>                                 |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hosp</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Grinder</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Owings Mill</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>224 Midpine Court</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>Harold</b> MIDDLE <b>Glass</b> LAST <b>Glass</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Agnes</b> MIDDLE <b>Lavery</b> LAST <b>Lavery</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO<br><b>187-14-1070</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs. Agnes Glass, wife, same as 13</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b><br><b>436-</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Gen Arteriosclerosis + Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Gen Arteriosclerosis + Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 Hr.</b><br><b>✓</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Pneumonia</b>   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Stephen Margolis</b>  |  |  |  | DEGREE<br><b>MD</b>   |  |   |  | 22c. DATE SIGNED<br><b>9/19/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Stephen Margolis</b>   |  |  |  | 22e. ADDRESS<br><b>1629 S. ... Rd ...</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Entombment</b>   |  | 23b. DATE<br><b>23 Sept. 80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Cecilia Mausoleum</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Rochester, Pennsylvania</b>                    |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>James S. Kirkley, Glen Burni</b>  |  |  |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 24 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |







FOR  
STATE  
REGISTRAR

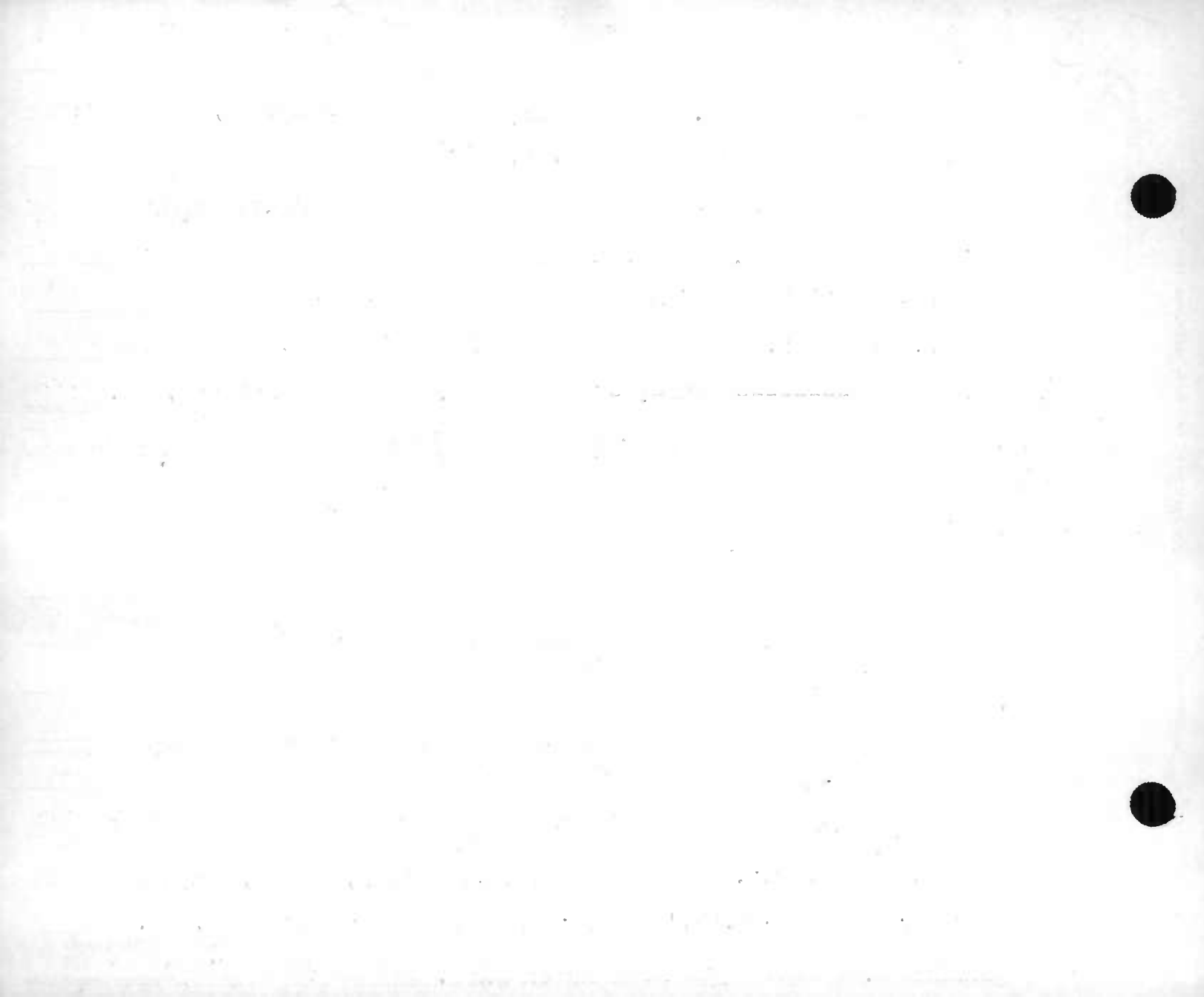
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 1 5 2

REG. NO.

|   |  |  |   |  |  |   |  |   |  |
|---|--|--|---|--|--|---|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Joseph A. Goedeke   |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>September 20, 1980              |  |  | 2b HOUR<br>A<br>11:30 M   |  |   |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 2, 1899  |  | 6 AGE (IN YEARS (LAST BIRTHDAY))<br>80 YRS.   |  | 7a IF UNDER 1 YEAR<br>MONTHS DAYS<br>7b IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7c BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7d CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Towson  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Josephs Hospital |   |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Bus Driver       |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Mass Transit  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b STATE<br>Maryland  |  |  | 13c COUNTY<br>21239   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e STREET ADDRESS<br>5306-B Leith Road                      |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Aloysius F. Goedeke  |  |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth M. Hefner                            |   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----       |  | 17 INFORMANT<br>ADDRESS<br>Marie E. Goedeke Baltimore, Md. 21239                               |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARCINOMA PROSTATE</u><br>185-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>18 mo.  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |  |   |  |   |  |
| 19a DATE OF OPERATION   |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a I certify that (this hospital) attended the deceased from <u>8-8</u> , 19 <u>80</u> , to <u>9-20</u> , 19 <u>80</u> , that (we) lost<br>saw the deceased alive on <u>9-20</u> , 19 <u>80</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated<br>above, (we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |   |  |
| 22b SIGNATURE<br><u>James Kleeman</u><br>DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |   |  |  | 22c. DATE SIGNED<br>9.20.80   |  |   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>James Kleeman M.D.  |  |  |   |  |  | 22e ADDRESS<br>7620 York Road, Towson, Maryland 21204                               |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>Sept. 23, '80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md. |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>William E. Johnson 8521 Loch Raven Blvd.   |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 22 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |

TO HOSPITALS, ATTENDING PHYSICIANS: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be delivered for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of a case.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 0 2 2 1 5 3   |  |  |  |
|---|--|--|--|---|--|--|--|
| FOR<br>STATE<br>REGISTRAR   |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Frank Earl GOHLINGHORST</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 27, 1980</b>  |  |  |  |
| 3. SEX<br><b>Male</b>   |  |  |  | 2b. HOUR<br><b>11:20 P.M.</b>   |  |  |  |
| 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept 14, 1911</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Beef Dresser</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Esskay</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  |  |  | 13b. CITY OR TOWN<br><b>Baltimore</b>   |  | 13c. STREET ADDRESS<br><b>3403 Lyndale Avenue</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank G. Gohlinghorst</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Jennie Packham</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-03-9207</b>  |  | 17. INFORMANT<br>ADDRESS <b>Balto., Md. 21213</b><br><b>Margaret Gohlinghorst 3403 Lyndale Avenue</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4275</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Ventricular Arrhythmia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>September 26, 1980</b> , <b>September 27, 1980</b> , that (X) (we) last saw the deceased alive on <b>September 27, 1980</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Peter Stahl M.D.</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>9/28/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Peter Stahl M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive 21237</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Oct 1, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Dippel Funeral Homes, Inc. 7110 Belair Rd.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 29 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |



Barryman

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Barryman

Franklin House Laundry

Post Office

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Frank W. Barryman

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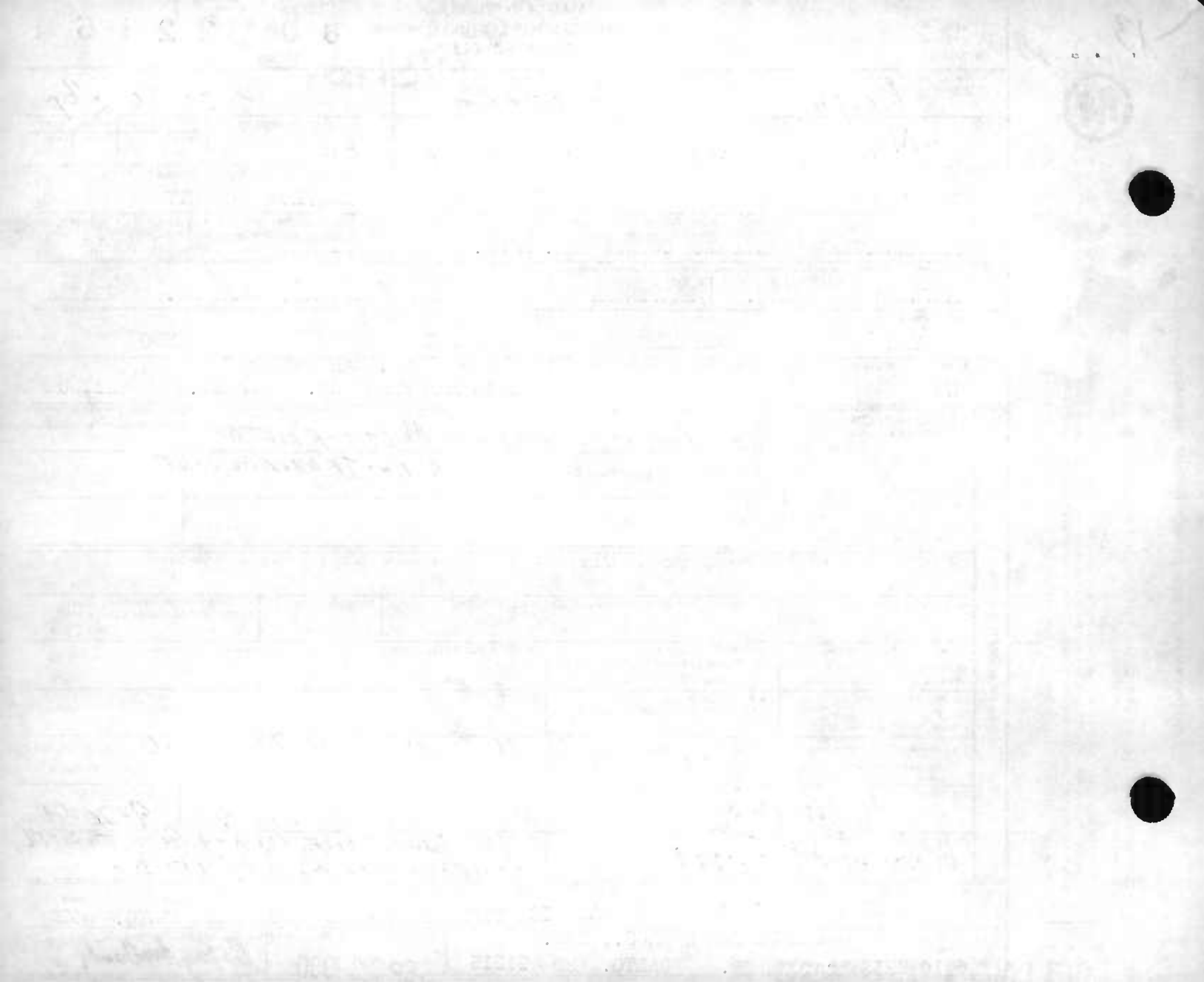
Barryman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 0 2 2 1 5 4<br>REG. NO.   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RALPH</b> <b>GOLDBERG</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>9-20-80</b> 2b. HOUR <b>2:16 P M</b>   |  |   |  |
| 3. SEX<br><b>M</b> <b>ALE</b>  |  | 4. RACE<br><b>CAUC</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>7-17-16</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS. <input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE COUNTY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE COUNTY GEN. HOSP.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DESIGNER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>TOOLS</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>BALTO.</b> 13c. CITY OR TOWN <b>BALTIMORE</b>  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>8214 ARROWHEAD RD. #21208</b>           |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>MYER GOLDBERG</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>SOPHIE RUDO</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES)  |  |   |  | 16b. SOCIAL SECURITY NO. <b>8214 ARROWHEAD RD. BALTO., MD 21208</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>GLIOBLASTOMA MULTIFORME OF</b><br><b>1912</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>RIGHT TEMPORAL LOBE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-20</b> <b>80</b> <b>9-10</b> 19 <b>80</b> , to <b>9-20</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>9-20</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.     |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>Wendy A. T. Kelly</b>  |  |   |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>9-20-80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wendy A. T. Kelly</b>   |  |   |  | 22e. ADDRESS <b>BALTIMORE COUNTY GEN HOSPITAL RANDALLSTOWN, MARYLAND</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>9/22/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>HAR ZION TIFERETH ISRAEL</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROSEDALE BALTO. MD</b>   |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b> NAME ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>SEP 23 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>John J. McHenry</b>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 0 2 2 1 5 5<br>REG. NO.   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>VIRGINIA K. GOLDSMITH   |  |  |  | September 14, 1980  |  |  |  | 2:45A.M.  |  |
| 3 SEX<br>Female   |  | 4 RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>May 14, 1901   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>79   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                 |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Lutherville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>College Manor Nursing Home |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Statistical Clerk  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>BALTO   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>602 Walker Avenue  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Anthony King   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Victoria Thomas   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>217-20-8386  |  | 17. INFORMANT ADDRESS<br>Mrs. Gloria Werth 14 Grafton St. Chevy Chase, MD.  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Diabetes mellitus, severe, unstable</u><br>2500 } DUE TO, OR AS A CONSEQUENCE OF _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>since 1966.</u> |  |  |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>arteriosclerotic heart disease with arrhythmias-at least 5 years.</u>   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br>none  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>no injury   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>10-10-76</u> , 19____, to <u>9-14-80</u> , 19____, that (I) (we) lost saw the deceased alive on <u>9-14-80</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Charles E. Ellicott M.D.  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>9-15-80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Charles E. Ellicott, M.D.  |  |  |  | 22e. ADDRESS<br>1134 York Road, Lutherville, Md.  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>9-17-1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Cockeysville Maryland                             |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Ruck Towson Funeral Home, Inc. Towson, Maryland  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 16 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>Anthony McBrady  |  |   |  |

BP \_\_\_\_\_

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 1 5 6

REG. NO.

|   |  |  |  |   |  |  |  |   |  |          |  |   |  |                               |  |
|---|--|--|--|---|--|--|--|---|--|----------|--|---|--|-------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST   |  | 2b. DATE OF DEATH MONTH DAY YEAR                                    |  |          |  | 2b. HOUR  |  |                               |  |
| CATHERINE   |  | A.   |  | GOLLER  |  | September 10, 1980   |  |   |  | 10:50 AM |  |   |  |                               |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |          |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                           |  |                               |  |
| Female  |  | White  |  | 11-12-13  |  |  |  | 66 YRS.   |  |          |  |   |  |                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |          |  | MD.   |  |                               |  |
| Balto. Md.  |  | U.S.A.   |  |   |  |  |  | Baltimore County  |  |          |  |   |  |                               |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |          |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                               |  |
| Towson  |  | Greater Baltimore Medical Center   |  |   |  |  |  | Home Maker  |  |          |  |   |  |                               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |  |  |   |  |          |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS           |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN  |  |  |  |   |  |  |  |   |  |          |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 1110 Sleepy Dell Court -21204 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  |   |  |  |  |   |  |          |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                          |  |                               |  |
| Albert Ay   |  |  |  |   |  |  |  |   |  |          |  | Katherine Ackerman  |  |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.  |  |  |  | 17. INFORMANT ADDRESS   |  |          |  |   |  |                               |  |
| No  |  |  |  | 219-05-92403<br>220-46-6231   |  |  |  | Mr. George N. Goller-1110 Sleepy Dell Ct. 21204                     |  |          |  |   |  |                               |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c):   |  |  |  |   |  |  |  |   |  |          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |                               |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |   |  |  |  |   |  |          |  |   |  |                               |  |
| IMMEDIATE CAUSE (a) Lymphocytic leukemia  |  |  |  |   |  |  |  |   |  |          |  |   |  |                               |  |
| 2049 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |  |   |  |          |  |   |  |                               |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |   |  |  |  |   |  |          |  |   |  |                               |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |  |  |   |  |          |  |   |  |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |  |  |  |   |  |  |  |   |  |          |  |   |  |                               |  |
| Severe arteriosclerotic cardiovascular disease  |  |  |  |   |  |  |  |   |  |          |  |   |  |                               |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |          |  |   |  |                               |  |
|   |  |  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |          |  |   |  |                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |          |  |   |  |                               |  |
|   |  | P.M. 19  |  |   |  |  |  |   |  |          |  |   |  |                               |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |          |  |   |  |                               |  |
|   |  |  |  |   |  |  |  |   |  |          |  |   |  |                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from September 10, 19 80, to September 10 19 80, that (I) (we) last saw the deceased alive on September 10, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |          |  |   |  |                               |  |
| 22b. SIGNATURE  |  |  |  |   |  | DEGREE   |  | 22c. DATE SIGNED  |  |          |  |   |  |                               |  |
| R. Breiteneker  |  |  |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 9/10/80   |  |          |  |   |  |                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |   |  | 22e. ADDRESS   |  |   |  |          |  |   |  |                               |  |
| Rudiger Breiteneker   |  |  |  |   |  | 6701 N. Charles St., Balto., Md. 21204   |  |   |  |          |  |   |  |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |          |  |   |  |                               |  |
| Burial  |  | 9-13-80  |  | Parkwood Cemetery   |  | Balto., Md.  |  |   |  |          |  |   |  |                               |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |          |  |   |  |                               |  |
| John C. Miller Inc-6415 Belair Rd.-21206  |  |  |  |   |  | SEP 15 1980  |  | R. Breiteneker  |  |          |  |   |  |                               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |        |  |      |  |   | 8022157   |  |   |  |   |                     |                  |  |          |  |
|---|--|--|---|--|--------|--|------|--|---|---|--|---|--|---|---------------------|------------------|--|----------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |  | REG. NO.  |  |        |  |      |  |   |   |  |   |  |   |                     |                  |  |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST   |  | MIDDLE |  | LAST |  | 2r. DATE OF DEATH   |   |  | MONTH   |  | DAY   |                     | YEAR             |  | 2b. HOUR |  |
| LILLIAN   |  |  | GORDON  |  |        |  |      |  | 9-16-80   |   |  | 342   |  | M   |                     |                  |  |          |  |
| 3 SEX   |  |  | 4 RACE  |  |        | 5 DATE OF BIRTH  |      |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                    |   |  | 7a. UNDER 1 YEAR  |  |   | 7b. UNDER 1 HRS     |                  |  |          |  |
| FEMALE  |  |  | WHITE   |  |        | JUNE 15, 1936  |      |  | 44  |   |  | MONTHS  |  |   | DAYS                |                  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |        | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                               |   |  |   |  |   |                     |                  |  |          |  |
| MARYLAND  |  |  | USA   |  |        |  |      |  | BALTIMORE CITY CO.  |   |  |   |  |   |                     |                  |  |          |  |
| 10 CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)  |      |  | 12b. KIND OF BUSINESS OR INDUSTRY                                 |   |  |   |  |   |                     |                  |  |          |  |
| RANDALLSTOWN  |  |  | BALTIMORE COUNTY GEN. HOSPITAL  |  |        | HOUSEWIFE  |      |  | APT. 8C   |   |  | AT HOME   |  |   |                     |                  |  |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  | 13a. STATE  |  |        | 13b. COUNTY  |      |  | 13c. CITY OR TOWN   |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   | 13e. STREET ADDRESS |                  |  |          |  |
| MARYLAND  |  |  |   |  |        | BALTIMORE  |      |  |   |   |  | 3619 GLENGYLE AVE. #21215   |  |   |                     |                  |  |          |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME  |  |        |  |      |  |   |   |  |   |  |   |                     |                  |  |          |  |
| FIRST   |  |  | MIDDLE  |  |        | LAST   |      |  | FIRST   |   |  | MIDDLE  |  |   | LAST                |                  |  |          |  |
| LEON  |  |  | CHAYT   |  |        | ROSE   |      |  | ROTTMAN   |   |  |   |  |   |                     |                  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.  |  |        | 17 INFORMANT   |      |  | ADDRESS   |   |  |   |  |   |                     |                  |  |          |  |
| NO  |  |  | 216-32-4538   |  |        | ALVIN GORDON   |      |  | 3619 GLENGYLE AVE.  |   |  | APT. 8-C  |  |   | BALTO., MD 21215    |                  |  |          |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) SEVERE ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE<br>2506<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) DIABETIS MELLITUS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                             |  |  |   |  |        |  |      |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |   |  |   |                     |                  |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |   |  |        |  |      |  |   |   |  |   |  |   |                     |                  |  |          |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |        | 20a. AUTOPSY?  |      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |   |  |   |  |   |                     |                  |  |          |  |
| 8-28-80   |  |  | GANGRENE @ BK AMPUTATION STUMP  |  |        | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |      |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |   |  |   |  |   |                     |                  |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |      |  |   |   |  |   |  |   |                     |                  |  |          |  |
|   |  |  | P.M. 19   |  |        |  |      |  |   |   |  |   |  |   |                     |                  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |        | 21f. LOCATION<br>STREET  |      |  | CITY OR TOWN  |   |  | COUNTY  |  |   | STATE               |                  |  |          |  |
|   |  |  |   |  |        |  |      |  |   |   |  |   |  |   |                     |                  |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-20 19 80, to 9-16 19 80, that (I) (we) lost<br>saw the deceased alive on 9-16 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |        |  |      |  |   | 22b. SIGNATURE                                  |  | DEGREE  |  | ATTENDING<br>PHYSICIAN <input type="checkbox"/> MEDICAL<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> |                     | 22c. DATE SIGNED |  |          |  |
|   |  |  | Orlando B. Conanan  |  |        |  |      |  | 9-16-80   |   |  |   |  |   |                     |                  |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS  |  |        |  |      |  |   |   |  |   |  |   |                     |                  |  |          |  |
| ORLANDO B. CONANAN, MD.   |  |  | BCH - RANDALLSTOWN MD. 21133  |  |        |  |      |  |   |   |  |   |  |   |                     |                  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |  | 23b. DATE   |  |        | 23c. NAME OF CEMETERY OR CREMATORY   |      |  | 23d. LOCATION<br>CITY OR TOWN                                     |   |  | COUNTY  |  |   | STATE               |                  |  |          |  |
| BURIAL  |  |  | SEPT. 18, 1980  |  |        | RUDOMER VEREIN   |      |  | ROSEDALE  |   |  | BALTO.  |  |   | MD                  |                  |  |          |  |
| 24 FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.  |  |  |   |  |        | 25a. DATE REC'D. BY REGISTRAR  |      |  |   |   |  | 25b. REGISTRAR'S  |  |   |                     |                  |  |          |  |
| NAME ADDRESS  |  |  |   |  |        | SEP 23 1980  |      |  |   |   |  | Rising  |  |   |                     |                  |  |          |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215  |  |  |   |  |        |  |      |  |   |   |  |   |  |   |                     |                  |  |          |  |

2182 1880



FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 1 5 8

REG. NO.

|  |  |  |  |  |  |   |  |   |
|--|--|--|--|--|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>BESSIE S GOYNES   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9 8 80  |  |  | 2b. HOUR<br>12 35<br>A M  |  |   |
| 3 SEX<br>F   | 4 RACE<br>B  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>5 19 06 | 6 AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS   |  |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   | 7b CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY CO. MD.                       |  |   |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Balt. Co. Gen. Hospital |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret. School Teacher |  |   | 12b KIND OF BUSINESS OR INDUSTRY                           |   |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>MD.  |  |  | 13b COUNTY<br>BALTO.   |  |  | 13c CITY OR TOWN<br>BALTO.  |  |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>George W. Smith   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma C. Boone   |  |  |   |  |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |  | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>NO  |  |  | 17 INFORMANT<br>THEODORE SMITH  |  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) 1749 METASTATIC DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CARCINOMA BREAST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |  |   |  |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |   |  |   |
| 19a DATE OF OPERATION  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |   |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |
| 22a I certify that (I) (this hospital) attended the deceased from 9-8-1980, to 9-8-1980, that (I) (we) last saw the deceased alive on 9-8-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |   |
| 22b SIGNATURE<br>George Kurian   |  |  | DEGREE   |  |  | 22c. DATE SIGNED<br>9-8-80  |  |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>GEORGE KURIAN  |  |  | 22e ADDRESS<br>Baltimore County Hospital   |  |  |   |  |   |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b DATE<br>9/13/80  |  | 23c NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem. |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md. |   |
| 24 FUNERAL DIRECTOR<br>NAME<br>Chas. H. Powell F/H   |  |  | ADDRESS<br>319 N. Schroeder  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 10 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>Anthony Kelly   |

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL-ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filed within 72 hours after death. The medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>LEVARN GRAHAM</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>SEPTEMBER 3, 1980</b>  |  |   |  |
| 3. SEX<br><b>MALE</b>   |  |  |  | 2b. HOUR<br><b>2:50 A.M.</b>  |  |   |  |
| 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>DECEMBER 16, 1925</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b> YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>SOUTH CAROLINA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VA MEDICAL CENTER</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.   |  |   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>AUTO MECHANIC</b>   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>HENRY GRAHAM</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>VICTORIA SINGLETARY</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>W.W. 11 250 28 6183</b>  |  | 17. INFORMANT ADDRESS<br><b>CLINICAL RECORDS, VAMC, FORT HOWARD, MD</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, BILATERAL, DIFFUSE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MULTIPLE LUNG ABSCESSSES, BILATERAL</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>                          |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>DAYS</b><br><b>DAYS</b><br><b>YEARS</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>MALNUTRITION</b>  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>AUGUST 29</b> 19 <b>80</b> , to <b>SEPTEMBER 3</b> 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>SEPTEMBER 3</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Vadhana C. Claud</i> MD.   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>9/3/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VADHANA C. CLAUD, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>VAMC, FORT HOWARD, MARYLAND 21052</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>9-9-80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Isaiah L. Brown &amp; Son PA 1913 W. Balto. St</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 5 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |   |   |  |          | REG. NO. 18022160 |  |
|---|--|--|--|---|---|---|---|--|----------|-------------------|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | 2a. DATE OF DEATH   |   | MONTH DAY YEAR  |  | 2b. HOUR |                   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <sup>FIRST</sup> Maggie <sup>MIDDLE</sup> McQueen <sup>LAST</sup> Grainger   |  |  |  |   | 09-22-80  |   | 2:40 P.M.   |  |          |                   |  |
| 3 SEX   |  | 4 RACE   |  | 5 DATE OF BIRTH   |   | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |   | IF UNDER 1 YEAR  |          | IF UNDER 24 HRS   |  |
| female  |  | white  |  | June 2, 1889  |   | 91 YRS  |   | MONTHS DAYS  |          | HOURS MIN.        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |   |  |          |                   |  |
| S.C.  |  | U.S.A.   |  |   |   | Baltimore County MD.  |   |  |          |                   |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |          |                   |  |
| Catonsville   |  | Summit Nursing Center  |  |   |   | housewife   |   | home   |          |                   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   | 13b. INSIDE CITY LIMITS?  |   | 13c. STREET ADDRESS   |  |          |                   |  |
| 13a. STATE Maryland 13b. COUNTY Howard 13c. CITY OR TOWN Columbia   |  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 10986 Swansfield Road   |  |          |                   |  |
| 14 FATHER'S NAME <sup>FIRST</sup> William <sup>MIDDLE</sup> McQueen <sup>LAST</sup>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME <sup>FIRST</sup> Margaret <sup>MIDDLE</sup> Hardwick <sup>LAST</sup>   |   |   |  |          |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no  |  |  |  |   | 16b. SOCIAL SECURITY NO. 250 64 6856  |   | 17 INFORMANT 10986 Swansfield Road Mrs. Mary Smith Columbia, Maryland 21044 |  |          |                   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Sepsis, most likely<br>4149<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Ischemic Bowel, Possible<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Advanced ASCVD<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 days |  |  |  |   |   |   |   |  |          |                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br>Hypertension, Coronary artery disease   |  |  |  |   |   |   |   |  |          |                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |          |                   |  |
|   |  |  |  |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |          |                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |  |          |                   |  |
|   |  | HOUR A.M. MONTH DAY YEAR P.M. 19   |  |   |   |   |   |  |          |                   |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION   |   |   |   |  |          |                   |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | STREET CITY OR TOWN COUNTY STATE  |   |   |   |  |          |                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-13-78, 19 --, to 9-22-80, 19 --, that (I) (we) last saw the deceased alive on 9-13-80, 19 --, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                 |  |  |  |   |   |   |   |  |          |                   |  |
| 22b. SIGNATURE  |  |  |  |   | DEGREE  |   |   | 22c. DATE SIGNED   |          |                   |  |
| Allan Perez M.D.  |  |  |  |   | M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   |  |          |                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |   | 22e. ADDRESS  |   |   |  |          |                   |  |
|   |  |  |  |   | 1009 Frederick Rd. Catonsville 21228  |   |   |  |          |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (CITY OR TOWN)  |   | COUNTY STATE   |          |                   |  |
| burial  |  | 9/26/80  |  | Pleasant View Cemetery  |   | Nichols   |   | S.C.   |          |                   |  |
| 24. FUNERAL DIRECTOR  |  |  |  |   | 25a. DATE RECEIVED BY FUNERAL DIRECTOR  |   | 25b. REGISTRAR'S SIGNATURE  |  |          |                   |  |
| SLACK Funeral Home, Ellicott City, Md. 21043  |  |  |  |   |   |   |   |  |          |                   |  |

STOCK funeral home, Elliotts City, Ok. 51043  
Pleasant View 7/25/80  
burial

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |                           | 80 22161  |  |                                       |  |
|--|--|--|--|---|--|--|--|---|---------------------------|---|--|---------------------------------------|--|
| FOR<br>1. STATE<br>REGISTRAR   |  |  |  |   |  |  |  |   |                           | REG. NO.  |  |                                       |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Mary Carmella Greco</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 26, 1980</b>                     |  |   | 2b. HOUR<br>M<br><b>M</b> |   |  |                                       |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>February 3, 1894</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>  |                           | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b>    |  |                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Italy</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |  |   |                           |   |  |                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Parkville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6850 A. Sturbridge Drive</b> |  |   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Tailor</b>   |                           | 12b. KIND OF BUSINESS OR INDUSTRY               |  |                                       |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. CITY OR TOWN<br><b>Balto.</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>6850 A. Sturbridge Drive</b>                               |  |   |                           |   |  |                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jacob Lamacchia</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>- Consiglia</b>   |  |  |  |   |                           |   |  |                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>214-01-5959A</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Antoinette Caruccio 5505 Whitwood Rd.</b>   |  |  |  |   |                           |   |  |                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute cardiac arrest, Chronic</b><br><b>5738</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>auricular fibrillation, Congestive Heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>Space occupying lesion Rt. lobe of liver.</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Arteriosclerosis C.V. Disease</b> |  |  |  |   |  |  |  |   |                           | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |                                       |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                           |   |  |                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>9 AM 9 26 Sept 80</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |                           |   |  |                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>St. Agnes Medical Center Baltimore, Md.</b>   |  |  |  |   |                           |   |  |                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9 Aug 80</b> to <b>26 Sept 80</b> that (I) (we) last saw the deceased alive on <b>25 Sept 80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |   |                           | 22b. SIGNATURE<br><b>Joseph E. Muse Jr M.D.</b> |  | 22c. DATE SIGNED<br><b>27 Sept 80</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph E. Muse MD</b>  |  |  |  | 22e. ADDRESS<br><b>St. Agnes Medical Center Baltimore, Md.</b>  |  |  |  |   |                           |   |  |                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Sept. 29, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Most Holy Redeemer</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>                                       |                           |   |  |                                       |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 30 1980</b>  |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |  |   |                           |   |  |                                       |  |



SEP 30 1980

Handwritten signature or initials.

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 0 2 2 1 6 2   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Macie Belview Gregory   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>September 21, 1980  |  | 2b. HOUR<br>3:07 a.m.  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Nov. 29, 1887  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD  |  |
| 10. CITY OR TOWN OF DEATH<br>Balto. Co.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Sq. Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Chase  |  | 13e. STREET ADDRESS<br>7341 Gunpowder Rd. Chase, Md.   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>James Albert Grimes   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Amanda A. Unknown   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>215-05-4443   |  | 17. INFORMANT ADDRESS<br>Mr. Charles Bridge, Same as above  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac arrest<br>5609<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>Complication of respiratory arrest<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>Small bowel obstruction<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (we) (this hospital) attended the deceased from September 17, 1980 to September 21, 1980, that (we) lost saw the deceased alive on September 20, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (I) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Miguel A. Montejó MD   |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>9/21/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Miguel A. Montejó, M.D.   |  | 22e. ADDRESS<br>9000 Franklin Square Drive 21237  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Sept. 24, 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland  |  |
| 24. FUNERAL DIRECTOR NAME<br>McCully Funeral Home, 130 E. Fort Ave. Balto. Md.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 22 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>Miguel A. Montejó  |  |

BP

675



1/19/18

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 1 6 3

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Stanley A GRIFFITH</b>                  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>September 6 1980</b>                   |   | 2b. HOUR<br><b>10:30p M</b>                         |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>9 9 1914</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b>                                  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.           |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) <b>MD</b>                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD</b>            |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Essex</b>                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANKLIN SQUARE</b> |   | 12a. USUAL OCCUPATION<br>(TYPE WORK FOR MOST OF WORKING LIFE) <b>Macinist</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Rt</b>  |   |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Balto</b>   | 13c. CITY OR TOWN<br><b>DUNDALK</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>17807 ST. GEORGEY DR.</b> |
| 14. FATHER'S NAME<br>FIRST MIDDLE <b>ROBERT Griffith</b>                       |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>MAMIE Catterton</b>  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b> |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>1-216 10 6562</b>  | 17. INFORMANT<br>ADDRESS <b>Mrs John Westaway #13</b>                         |   |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Respiratory arrest****2030**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Pneumonia**

DUE TO, OR AS A CONSEQUENCE OF

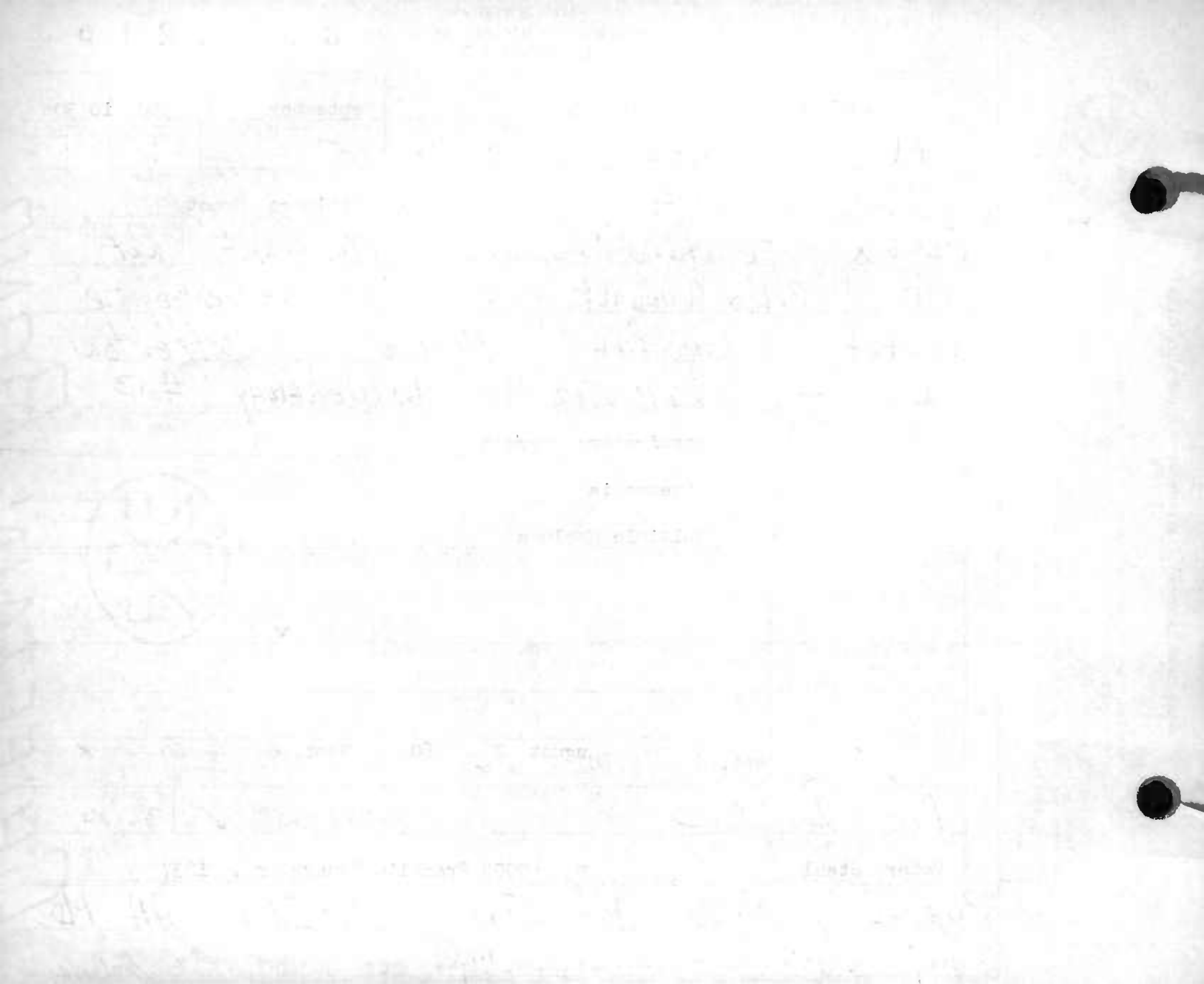
(c) **Multiple Myeloma**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

|  |  |  |  |
|--|--|--|--|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 2</b> , 19 <b>80</b> , to <b>Sept. 6</b> , 19 <b>80</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>Sept. 6</b> , 19 <b>80</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Peter Stahl MD</b>  | DEGREE   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>9/6/80</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Peter Stahl</b>  |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>   |  |

|  |                            |  |   |
|--|----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>                               | 23b. DATE<br><b>9/8/80</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT ZION</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>MT ZION AA MD</b> |
| 24. FUNERAL DIRECTOR<br>NAME <b>John M. Lytle &amp; Sons</b> ADDRESS <b>Annapolis MD</b> |                            | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 10 1980</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Pinkney McCreedy</b>           |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 0 2 2 1 6 4<br>REG. NO.   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>May Grubb</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>September 11, 1980</b>   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>April 30, 1890</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville 21237</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Essex 21221</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>George - Gootee</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Julia - Stevenson</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>214 56 3684</b>  |  | 17. INFORMANT (Son) ADDRESS<br><b>Carl D. Hubert Same</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>4140</b> |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Enrique A. Herrera</i>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Enrique A. Herrera, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>620 Eastern Blvd., Balto. Md. 21221</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>9-13-80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cem.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore County, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br><i>Bruzdinski</i>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 16 1980</b>   |  |  |  |
| 24. FUNERAL HOME<br><b>Bruzdinski Funeral Home PA 1407 Old Eastern Ave</b>   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert McBratney</i>   |  |  |  |

BP



Arteriosclerotic Heart Disease  
Cardiac Arrhythmias

Enrique A. Herrera, M.D. 620 Eastern Blvd., Balto. Md. 21221

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. The certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |                              | 8022165                                      |  |
|--|--|---|--|---|--|---|--|--|------------------------------|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  |   |  |   |  |  |                              |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Joseph M Guerin</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 30, 1980</b>                                |  |  | 2b. HOUR<br><b>8:00 A.M.</b> |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 16 1935</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>44</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>   |                              | IF UNDER 74 HRS.<br>HOURS MIN.<br><b>0 0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |  |                              |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Putty Hill</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>29 Coatsbridge Ct</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Carpenter</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Shipyard</b>   |                              |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |   |  |  |                              |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>29 Coatsbridge Ct.</b>   |                              |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William J. Guerin Sr.</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah J. Murphy</b>   |  |   |  |  |                              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-32-3287</b>  |  | 17. INFORMANT<br><b>Albert Guerin</b>   |  | ADDRESS<br><b>1144 Northern Pkwy</b>  |  |  |                              |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Renal Cell Carcinoma</b><br><b>1890</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  |  |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |  |                              |  |  |
| 19a. DATE OF OPERATION<br><b>-</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                              |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |                              |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/3</b> , 19 <b>80</b> , to <b>9/30</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>9/16</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |  |   |  |   |  |   |  |  |                              |  |  |
| 22b. SIGNATURE<br><b>Davis Hahn</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  |   |  | 22c. DATE SIGNED<br><b>7/30/80</b>   |                              |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Davis Hahn M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>5601 Dk Loch Raven Blvd Baltimore, Md</b>  |  |   |  |  |                              |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10-3-80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |  |  |                              |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 1 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McCreedy</b>  |  |  |                              |  |  |

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 1 6 6

REG. NO.

|  |  |   |   |   |                            |
|--|--|---|---|---|----------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Ruby Julia Haddaway</i>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>9 22 1980</i>   |   | 2b. HOUR<br>M<br><i>AM</i> |
| 3. SEX<br><i>Female</i>  | 4. RACE<br><i>White</i>                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>4 6 1902</i>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><i>78</i>  |                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MD</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.                             |                            |
| 10. CITY OR TOWN OF DEATH<br><i>Randallstown</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>8619 Church Lane</i>                        |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Homemaker</i>            |                            |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><i>-</i>  |  |   |   |   |                            |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |   |                            |
| 13a. STATE<br><i>MD</i>  | 13b. COUNTY<br><i>Baltimore</i>            | 13c. CITY OR TOWN<br><i>Randallstown</i>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><i>8619 Church Lane</i>  |                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>John Clinton Peddicord</i>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Julia Ann Moxley</i>                        |   |                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>216-32-2044</i>   |   | 17. INFORMANT<br><i>John Austin Haddaway</i><br><i>8619 Church Lane, Randallstown, MD 21133</i> |                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>MYOCARDIAL INFARCTION</i><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>ARTERIO SCLEROTIC HEART DISEASE</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>HYPERTENSIVE C.V. DISEASE</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 HR.</i><br><i>20 YRS</i><br><i>25 YRS</i> |  |   |   |   |                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |                            |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                            |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |   |                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>JUNE 19 50</i> to <i>SEPT 22 19 80</i> , that (I) (we) last saw the deceased alive on <i>SEPT 17 19 80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (you) (did) (did not) view the body after death.)   |  |   |   |   |                            |
| 22b. SIGNATURE<br><i>Thomas E. Wheeler</i>   |  | DEGREE<br><i>MD</i>   |   | 22c. DATE SIGNED<br><i>9/23/80</i>  |                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>THOMAS E. WHEELER</i>  |  | 22e. ADDRESS<br><i>2542 MELBA ROAD ELLICOTT CITY MD</i>   |   |   |                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>9/25/80</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Lake View Mem. Park</i>                                |                            |
| 23d. LOCATION<br>CITY OR TOWN<br><i>Sykesville</i>   |  | 23e. COUNTY<br><i>Carroll</i>   |   | 23f. STATE<br><i>MD</i>   |                            |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Loring Byers Funeral Directors, P.A.</i>  |  | 24b. ADDRESS<br><i>8728 Liberty Rd., Randallstown, MD 21133</i>   |   | 25a. DATE REC'D. BY REGISTRAR<br><i>SEP 23 1980</i>   |                            |

MEDICAL CERTIFICATION

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 22167

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |  |  |   |  |   |  |
|---|--|--|--|--|--|---|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>ARNOLD</b>   |  | FIRST<br><b>HANAUER</b>  |  | LAST<br><b>HANAUER</b>   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 19 80</b>  |  | 2b HOUR<br><b>7:14 PM</b>   |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>WHITE</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JUNE 10, 1903</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b>   |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>GERMANY</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE COUNTY</b> MD.                     |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>8329 MINDALE CIRCLE APT. C (21207)</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SUPERVISER</b>          |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>HECHT CO.</b>  |  |
| 13a STATE<br><b>MARYLAND</b>  |  | 13b COUNTY<br><b>BALTIMORE</b>   |  | 13c CITY OR TOWN<br><b>BALTO.</b>  |  | 13d INSIDE CITY LIMITS<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SALLY HANAUER</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELLR HESS</b>  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |   |  |   |  |
| 16b SOCIAL SECURITY NO.<br><b>220-09-6514</b>   |  | 17 INFORMANT ADDRESS<br><b>MRS LEONIE HANAUER 8329 MINDALE CIRCLE APT. C. (21207)</b>  |  |  |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a):<br><b>410- Sudden myocardial infarct</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>generalized arteriosclerosis</b>                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>acute 15 min</b>  |  |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):   |  |  |  |  |  |   |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a I certify that (a) (this hospital) attended the deceased from <b>July 19 68</b> , to <b>7-19 80</b> , that (b) (we) last saw the deceased alive on <b>July 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |   |  |
| 22b SIGNATURE<br><b>H. Gerald Oster</b>   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  |   |  | 22c DATE SIGNED<br><b>9/20/80</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>H. Gerald Oster</b>  |  | 22e ADDRESS<br><b>3635 Old Court Road</b>  |  |  |  |   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(CHECK ONE)<br><b>BURIAL</b>  |  | 23b DATE<br><b>9-21-80</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>CHEVRA AHAVAS CHESSED</b>  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>RANDALLSTOWN, BALTO MD</b>                    |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>SOL LEV, NSON &amp; BROS</b>  |  | 6010 REGISTERSTOWN RD.<br>BALTIMORE, MD. (21215)   |  | 25a DATE REC'D. BY REGISTRAR<br><b>SEP 23 1980</b>   |  | 25b REGISTRAR'S SIGNATURE<br><b>L. J. McHenry</b>   |  |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.



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STANDARD FORM NO. 64



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   | 8022168   |  |  |  |  |  |
|--|--|---|--|---|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   | REG. NO.  |  |  |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>ERNEST HARDY</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>5</b> YEAR <b>80</b>                                 |  |  |  | 2b. HOUR<br><b>2:40P.M.</b>                  |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>CAUC</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>13</b> YEAR <b>1900</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 74 HRS.<br>HOURS <b></b> MIN. <b></b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>SHEFFIELD, ENGLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>BRITISH</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Halethorpe</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1706 Arbutus Avenue</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MFG. ENGINEER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTO</b>   |  | 13c. CITY OR TOWN<br><b>Halethorpe</b>  |   | 13e. STREET ADDRESS<br><b>1706 ARBUTUS AVE</b>   |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Robert Hardy</b> MIDDLE <b></b> LAST <b></b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Sophie Arnold</b> MIDDLE <b></b> LAST <b></b>              |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>015-03-7307</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Yvonne G. Hardy 1706 Arbutus Avenue</b>  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>496- CHRONIC OBSTRUCTIVE LUNG DISEASE</b><br>IMMEDIATE CAUSE (a) <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>YRS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b></b>                    |  |   |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |
| 22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>3-29</b> , 19 <b>78</b> to <b>9-5</b> , 19 <b>80</b> , that (I) <del>(last)</del> saw the deceased alive on <b>8-12</b> , 19 <b>80</b> , and that in (my) <del>(own)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(was)</del> (did) (did not) view the body after death. |  |   |  |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Laurence R. Gallagher, MD</b>   |  |   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>9-5-80</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LAURENCE R. GALLAGHER</b>  |  |   |  |   |   | 22e. ADDRESS<br><b>ST AGNES MEDICAL CENTER<br/>WILKENS + PINE HEIGHTS</b>  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>burial</b>   |  |   | 23b. DATE<br><b>9/8/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Cemetery</b>                               |  |  | 23d. LOCATION<br>CITY OR TOWN <b>Dorsey</b> COUNTY <b>Howard</b> STATE <b>Maryland</b>                                     |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Ambrose Funeral Home</b> ADDRESS <b>1328 Sulphur Spring Rd.</b>  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 8 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |

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SEP 8 1980

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  | 8022169<br>REG. NO.  |  |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) Col. James Grady Hattox   |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>September 4, 1980       |  |  | 2b. HOUR<br>9:45 AM  |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>June 27, 1909   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.  |  | 7 UNDER 1 YEAR<br>MONTHS DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Mississippi   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Lutherville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>51 Thornhill Road |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret. Military  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Officer   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Lutherville   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br>51 Thornhill Road   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Hattox  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Maggie Graddy |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII & Korea  |  | 17 INFORMANT<br>Mrs. Doris Hattox  |  | ADDRESS<br>Same as #13.  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>respiratory arrest</u><br>185-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>metastatic prostatic carcinoma</u>  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><u>none</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>-</u>   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (1) (the hospital) attended the deceased from <u>8/15</u> 19 <u>80</u> to <u>9</u> 19 <u>80</u> , that (1) (we) last saw the deceased alive on <u>8/15</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.   |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>C. R. McCough</u>   |  |  |  | DEGREE<br><u>MD</u>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>9/5/80</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Charles McCough, M.D.   |  |  |  | 22e. ADDRESS<br>Johns Hopkins Hospital Baltimore, Maryland   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Sept. 8, 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National Cen. Arlington, Virginia  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc.  |  |  |  | ADDRESS<br>1050 York Road Towson, Md. 21204  |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 9 1980  |  | 25b. REGISTRAR<br><u>[Signature]</u>   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSMIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  | REG. NO. 22170   |  |
|---|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Robert Haynie</b>  |  |   |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH <input checked="" type="checkbox"/> DAY 9 YEAR 5 1980 |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH 2 DAY 20 YEAR 54  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY 26 YRS.  |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>                            |  | 2c. DATE PRONOUNCED DEAD<br>MONTH 9 DAY 5 YEAR 1980   |  | 2d. HOUR<br><b>9:10 A.M.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Owings Mills</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Rosewood Hospital Center</b> |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2202 Morris St.</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Eugene</b> MIDDLE LAST <b>Ennis</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Laura</b> MIDDLE LAST <b>Carpenter</b>   |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>N/A</b>  |  |   |  | 17. INFORMANT<br><b>Laura Sutton</b>  |  |   |  | ADDRESS<br><b>342 W. Bloom St.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>7803 Drowning Seizure Disorder</b><br>IMMEDIATE CAUSE (a) <b>Drowning Seizure Disorder</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Seizure Disorder</b>  |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>9:00 AM 9-5-80</b>  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject drowned in bathtub</b>                |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>bathtub</b>   |  |   |  | 21f. LOCATION<br>STREET <b>Rosewood Hospital Center</b> CITY OR TOWN <b>Owings Mills</b> COUNTY <b>Baltimore</b> STATE <b>Md.</b> |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>Virginia L. Dolan</b>  |  |   |  | TITLE (SPECIFY)<br><b>Assistant</b>   |  |   |  | DATE SIGNED<br><b>9/5/80</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>   |  |   |  | ADDRESS<br><b>111 Penn Street</b>   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   |  | 23b. DATE<br><b>9/11/80</b>   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Park</b>   |  |  |  |
| 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Baltimore</b> STATE <b>MD</b>  |  |   |  | 23e. DATE REC'D. BY REGISTRAR<br><b>SEP 9 1980</b>  |  |   |  | 23f. SIGNATURE<br><b>[Signature]</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm. C. March F/H</b> ADDRESS <b>1101 E. North Ave.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 9 1980</b>  |  |   |  | 25b. SIGNATURE<br><b>[Signature]</b>  |  |  |  |

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 1 7 1

REG. NO.

|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>MARY ELLEN HAY WORTH</b>   |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>9-22-80</b> |  |  | 2b HOUR<br><b>6:42 P.M.</b>  |  |  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>Cauc</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7-5-01</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.   |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b>          |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Hairdresser</b>          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self employed</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |  |  |  |  |  |
| 13a STATE<br><b>MD</b>   |  | 13b COUNTY<br><b>Baltimore</b>   |  | 13c CITY OR TOWN<br><b>Rockdale</b>  |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e STREET ADDRESS<br><b>3526 St. James Road</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Wares</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Della Peddicord</b>  |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>-</b>   |  | 17 INFORMANT<br>ADDRESS<br><b>Mrs. Dorothy Blackburn<br/>6404 Kriel St., Baltimore, MD 21207</b>   |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>410- ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>N/A</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-22-80</b> to <b>9-22-80</b> , that (I) (we) last saw the deceased alive on <b>9-22-80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>9-22-80</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VUNDYALA V. REDDY</b>  |  | 22e. ADDRESS<br><b>BALTIMORE COUNTY GEN. HOSPITAL<br/>RANDALLSTOWN, MD 21133</b>   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>9/26/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olive Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Randallstown Baltimore MD</b>                 |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Buers Funeral Directors, P.A.<br/>8728 Liberty Rd., Randallstown, MD 21133</b>   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 23 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   | REG. NO.  |  |
|--|--|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Walter Jerome Heck</i>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>9 4 80</i>                                   |   | 2b. HOUR<br><i>6 A M</i>  |  |
| 3 SEX<br><i>M</i>  | 4 RACE<br><i>white</i>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>4 23 92</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>88</i>  |   | 7. YRS.<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Balto, Md</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto County</i> MD.   |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Cockeysville</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Maryland Masonic Home</i> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Pole Inspector</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Utility</i>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>  |  |   | 13b. CITY<br><i>Baltimore</i>  | 13c. CITY OR TOWN<br><i>Timonium</i>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>John C. Heck</i>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Catherine Bowen</i>                |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>212-05-5801</i>  |  | 17. INFORMANT ADDRESS<br><i>Rephaw Albert F. Hup VA 5-5247</i>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Chronic Obstructive Pul. Dis.</i><br><i>496-</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chr. Heart Failure</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>1 yr.</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 yr.</i>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  |  |   |  |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>9-3-80</i> P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK NOT AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (1) <del>(the decedent)</del> attended the deceased from <i>12-1-75</i> 19____, to <i>9/4/80</i> 19____, that (1) <del>(we)</del> last saw the deceased alive on <i>9-3-80</i> 19____, and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>(we)</del> (did) <del>(did not)</del> view the body after death.     |  |   |  |   |   |  |
| 22b. SIGNATURE<br><i>Walter E. Karfain</i>   |  | DEGREE<br><i>M.D.</i>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><i>9/4/80</i>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>WALTER E. KARFAIN</i>  |  | 22e. ADDRESS<br><i>MD. MASONIC HOME</i>   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>Sept. 6, 1980</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Baltimore</i>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore City, Maryland</i>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Mitchell-Wiedefeld Home, Inc.</i>   |  | ADDRESS<br><i>6500 York Rd. Baltimore, Md.</i>  |  | 25. BY STATE REGISTRY<br><i>SEP 10 1980</i>   |   |  |

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SEP 10 1932

RECEIVED  
U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8 0 2 2 1 7 3

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH   |   | 2b. HOUR   |  |
| 1 DECEASED NAME (TYPE OR PRINT)   |  | MONTH DAY YEAR  |   | 19 P M   |  |
| Elsie May Held  |  | September 7, 1980   |   |  |  |
| 3 SEX   | 4 RACE   | 5 DATE OF BIRTH   | 6 AGE (IN YEARS LAST BIRTHDAY)                                      | 7. IF UNDER 1 YEAR   |  |
| Female  | White  | MONTH DAY YEAR  | 99 YRS.   | IF UNDER 24 HRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |  |
| Maryland  | U.S.A.   |   | Baltimore County, MD.   |  |  |
| 10 CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |
| Towson  | 309 W. Pennsylvania Ave.   | Home Maker  | Own Home  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |  |  |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS  |  |
| Maryland  | Baltimore  | Towson  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 309 W. Pennsylvania Ave.   |  |
| 14 FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |   |  |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST   |   |  |  |
| Harry Phipps  |  | Ruth Anna Gorsuch   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS  |  |
| No  |  | 220-44-8427   |   | Charles W. Held, Jr. 1 Greenridge Road   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)  |  |   |   |  |  |
| PART 1. DEATH WAS CAUSED BY:  |  |   |   |  |  |
| IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>  |  |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Coronary Artery Disease</u>   |  |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>5 yrs</u>   |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?  |  |
|   |  |   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
|   |  | HOUR A.M. MONTH DAY YEAR  |   |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY  |   | 21f. LOCATION  |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>July 19, 60 to September 7, 80</u> , that (I) (we) lost saw the deceased alive on <u>September 80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE  |  | DEGREE  |   | 22c. DATE SIGNED   |  |
| <u>Charles F. O'Donnell</u>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |   | 9/7/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |   |  |  |
| Charles F. O'Donnell, M.D.  |  | 7501 York Road Towson, Maryland 21204   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial  |  | Sept. 10, 1980  |   | Prospect Hill Cem.   |  |
| 23d. LOCATION   |  | 23e. DATE REC'D. BY REGISTRAR   |   | 23f. REGISTRAR'S SIGNATURE   |  |
| CITY OR TOWN COUNTY STATE   |  | SEP 9 1980  |   | <u>Richard M. B...</u>   |  |
| Towson Baltimore, Md.   |  |   |   |  |  |
| 24 FUNERAL DIRECTOR NAME  |  | ADDRESS   |   | 25. DATE REC'D. BY REGISTRAR   |  |
| Ruck Towson Funeral Home, Inc.  |  | 1050 York Road Towson, Md. 21204  |   | SEP 9 1980   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Add. Info. Film G549 11/6/80 kam

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

0 22174

|  |         |  |  |  |  |   |  |   |  |                          |  |   |  |          |  |
|--|---------|--|--|--|--|---|--|---|--|--------------------------|--|---|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE KNOWN OF DEATH   |  |                          |  | 2b. HOUR  |  |          |  |
| Daniel Earl Henning  |         |  |  |  |  |   |  | <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR<br>9 22 9 80 |  |                          |  | <input type="checkbox"/> M<br>5:35 P M                              |  |          |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)  |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.  |  | 7c. DATE PRONOUNCED DEAD |  |   |  | 7d. HOUR |  |
| Male   | White   | 7 5 1946   |  | 34 YRS.  |  |   |  |   |  | 10 6 19 80               |  |   |  | 5:35 P M |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED   |  | NEVER MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                          |  |   |  |          |  |
| North Carolina   |         | U.S.A.   |  | <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED |  | <input checked="" type="checkbox"/>                                 |  | Baltimore County,   |  |                          |  | MD.   |  |          |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)      |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |                          |  |   |  |          |  |
| Chase  |         | wooded area off Eastern Avenue                           |  | Mechanic   |  | Confidential Can Co.  |  |   |  |                          |  |   |  |          |  |
| 13a. STATE   |         | 13b. CITY OR TOWN  |  | 13c. CITY LIMITS?  |  | 13d. STREET ADDRESS   |  |   |  |                          |  |   |  |          |  |
| Md.  |         | Baltimore  |  | Baltimore  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 7307 Detz Ave.  |  |                          |  |   |  |          |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME                                 |  |  |  |   |  |   |  |                          |  |   |  |          |  |
| John F. Henning  |         | Bonnie Wollard   |  |  |  |   |  |   |  |                          |  |   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.                                 |  | 17. INFORMANT  |  | ADDRESS   |  |   |  |                          |  |   |  |          |  |
| Yes  |         | Navy 196-?   |  | 213-46-2420  |  | Lou Matthai (Brother in Law)  |  | Baltimore Md.   |  |                          |  |   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |  |  |  |   |  |   |  |                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |          |  |
| PART I DEATH WAS CAUSED BY:  |         |  |  |  |  |   |  |   |  |                          |  |   |  |          |  |
| IMMEDIATE CAUSE (a) Gunshot wound of head  |         |  |  |  |  |   |  |   |  |                          |  |   |  |          |  |
| 9654<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |         |  |  |  |  |   |  |   |  |                          |  |   |  |          |  |
| (b)  |         |  |  |  |  |   |  |   |  |                          |  |   |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |  |  |   |  |   |  |                          |  |   |  |          |  |
| (c)  |         |  |  |  |  |   |  |   |  |                          |  |   |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |         |  |  |  |  |   |  |   |  |                          |  |   |  |          |  |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                  |  |   |  |   |  |                          |  | 20. AUTOPSY?  |  |          |  |
|  |         |  |  |  |  |   |  |   |  |                          |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |  |  | 21b. TIME OF INJURY  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                     |  |                          |  |   |  |          |  |
|  |         |  |  | ? P.M. 9/22 19 80  |  |   |  | Subject Shot  |  |                          |  |   |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)        |  |   |  | 21f. LOCATION   |  |                          |  |   |  |          |  |
|  |         |  |  | Wooded Area  |  |   |  | Eastern Ave., Essex Balto., Md.   |  |                          |  |   |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on, and in my opinion death resulted from:  |         |  |  |  |  |   |  |   |  |                          |  |   |  |          |  |
| Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |  |  |  |   |  |   |  |                          |  |   |  |          |  |
| ACTUAL SIGNATURE   |         |  |  | TITLE (SPECIFY)  |  |   |  | DATE SIGNED   |  |                          |  |   |  |          |  |
| Thomas D. Smith, M.D.  |         |  |  | Deputy Chief   |  |   |  | 10/7/80   |  |                          |  |   |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |  |  | ADDRESS  |  |   |  |   |  |                          |  |   |  |          |  |
| Thomas D. Smith, M.D.  |         |  |  | 111 Penn Street  |  |   |  |   |  |                          |  |   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |  |  | 23b. DATE  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                          |  | 23d. LOCATION   |  |          |  |
| Burial   |         |  |  | 10/11/1980   |  |   |  | Pimlico Memorial Gardens  |  |                          |  | Washington N.C.   |  |          |  |
| 24. FUNERAL DIRECTOR   |         |  |  | 25a. DATE REC'D. BY REGISTRAR                                      |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |                          |  |   |  |          |  |
| E. Barnes Fleming Funeral Service  |         |  |  | Benson, Md. 21018  |  |   |  | OCT 20 1980   |  |                          |  | History McBrady   |  |          |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **22175**

**1- FOR  
STATE  
REGISTRAR**

|  |                  |  |  |   |   |  |
|--|------------------|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>AUGUST L. HERBERT</b> |                  |  | 2a. DATE KNOWN OF DEATH <b>9 19 80</b> |   | 2b. HOUR <b>8:45 P.M.</b>   |  |
| 3. SEX <b>M</b>  | 4. RACE <b>W</b> | 5. DATE OF BIRTH <b>AUG. 28, 1899</b>  | 6. AGE (IN YEARS) <b>81 YRS.</b>       | IF UNDER 1 YR. MONTHS DAYS  | IF UNDER 24 HRS. HOURS MIN  | 2c. DATE PRONOUNCED DEAD <b>9 19 80</b>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>         |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CO.</b>                                       |
| 10. CITY OR TOWN OF DEATH <b>REISTERSTOWN</b>                |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10 CHERRYHILL RD.</b> |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALESMAN</b> |  |
| 13a. STATE <b>MD.</b>  |                  | 13b. COUNTY <b>BALTO.</b>  |  | 13c. CITY OR TOWN <b>REISTERSTOWN</b>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME <b>LAWRENCE</b>                            |                  | 15. MOTHER'S MAIDEN NAME <b>RITA MAUER</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>  |   |  |
| 16b. SOCIAL SECURITY NO. <b>212-10-2379</b>                  |                  | 17. INFORMANT <b>Lois M. HERBERT</b>   |  | ADDRESS <b>SAME.</b>  |   |  |

|  |  |  |  |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b> |  |
| (b) <b>Arteriosclerotic C.V. Disease</b>   |  | <b>years</b>   |  |
| (c)  |  |  |  |

|   |  |   |  |
|---|--|---|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19        |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |
| 21f. LOCATION STREET  |  | CITY OR TOWN COUNTY STATE                                   |  |

|  |  |   |  |
|--|--|---|--|
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |
| ACTUAL SIGNATURE <b>Martin E. Strobel</b>  |  | TITLE (SPECIFY) <b>Deputy MEDICAL EXAMINER</b>  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Martin E. Strobel, M.D.</b>   |  | DATE SIGNED <b>9-20-80</b>                      |  |
|  |  | ADDRESS <b>59 Hanover Rd. Reisterstown, Md.</b> |  |

|  |  |                                     |  |  |  |                                     |  |
|--|--|-------------------------------------|--|--|--|-------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>BURIAL</b> |  | 23b. DATE <b>9-22-80</b>            |  | 23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATH. CEM.</b> |  | 23d. LOCATION <b>BALTO. MD.</b>     |  |
| 24. FUNERAL DIRECTOR NAME <b>NEWELL F.H.</b>         |  | ADDRESS <b>1100 REISTERSTOWN RD</b> |  | 25a. DATE <b>SEP 25 1980</b>                             |  | 25b. RECEIVED BY <b>[Signature]</b> |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, FILE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201







DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 1 7 6

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |  |   |  |   |  |  |
|---|--|--|--|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>John John M. Herring</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 22 80</b>  |  |   | 2b. HOUR<br><b>M</b>   |   |  |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 29 1899</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Essex</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Riverview Nursing Home</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Coal Miner</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>United Mine Workers</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Dundalk</b>                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Herring</b>   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Period Wright</b>                           |  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |   |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>209-01-9280</b>  |  |  | 17 INFORMANT<br><b>Mary E. Herring</b><br>ADDRESS<br><b>2907 Dunmore Rd. Balto., Md. 21222</b> |  |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Coronary Vascular Disease</b><br><b>4140</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Cerebrovascular Insufficiency. Organic Brain Syndrome</b>   |  |  |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                     |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                         |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.   |  |  |  |  |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Michael Schwartz M.D.</b>  |  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>9/22/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |   | 22e. ADDRESS   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>9/26/1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                              |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b><br><b>7922 Wise Ave. Dundalk, Md. 21222</b>  |  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 25 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State-Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State-Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 2 1 7 7

REG. NO.

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Ruth E. Hess</b>  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 9, 1980</b>   |  | 2b. HOUR AM<br><b>7:48 M</b>  |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>August 29 1925</b>   |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>55</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph's Hospital</b>                   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Waitress</b>                         |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |   | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Elmer E. Dickerhoff</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bessie Haller</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br><b>No</b> |  |
| 16b. SOCIAL SECURITY NO.<br><b>217-18-8820</b>  |   | 17. INFORMANT ADDRESS<br><b>Mr. Robert Jenkins 5201 Hampnett Ave.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>410- Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>1 day</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |   |   |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>9-5-</b> 19 <b>80</b> to <b>9-9-</b> 19 <b>80</b> , that (we) last saw the deceased alive on <b>9-9-</b> 19 <b>80</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>AH Ghiladi, MD</b>   |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>9-9-80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>AH. GHILADI, MD.</b>  |   | 22e. ADDRESS<br><b>7600 OSLER Dr. Towson 21204</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>Sept. 12, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sideling Hill</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Needmore, Fulton Co. Penn.</b>   |   | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 10 1980</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the date with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 0 2 2 1 7 8<br>REG. NO.   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Elsie M. Heyder   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>9 13 80   |  | 2b. HOUR<br>11:15 <sup>a</sup> M   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Feb. 14, 1898  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore, County MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Rosedale  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>8431 Avery Rd. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Rosedale   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>George - Akers  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Ann - Shaffer   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>-  |  | 17. INFORMANT ADDRESS<br>212-74-1445 May F. Bennett, dghtr., same address   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i><br>410 -<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <i>Coronary Arteriosclerosis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i></i> |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>7/10/70</i> to <i>9/23/80</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (I/did) did not view the body after death.  |  |  |  |   |  |  |  |
| 23a. SIGNATURE<br><i>William M. Smith</i>  |  |  |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  | 23c. DATE SIGNED<br>9/15/80  |  |
| 24a. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Meredith W. Smith, M.D.   |  |  |  | 24b. ADDRESS<br>1900 E. Northern Pkwy.  |  |  |  |
| 25a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 25b. DATE<br>9/16/80   |  | 25c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cem.   |  | 25d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Md.  |  |
| 26. FUNERAL DIRECTOR<br>Sonimunek Funeral Home, Inc.,  |  |  |  | 26b. ADDRESS<br>3331 Brehms Lane Balto., Md. 21213  |  | 27. DATE REGD. BY REGISTRAR<br>SEP 16 1980   |  |
|  |  |  |  | 28. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |



*Handwritten signature or mark.*

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 2 1 7 9

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |  |   |   |  |  |
|---|--|---|--|---|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>John O'Rian Hickey</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 22, 1980</b>             |   |  | 2b. HOUR<br><b>7:05a</b>   |   |   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 19, 1916</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b>   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS</b>   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Missouri</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Personnel Labor</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Relations</b>   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Lutherville</b>                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Hickey</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine Raus</b>   |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |   |   |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>491-07-1429</b>  |  |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Geraldine M. Hickey Same as #13.</b> |   |  |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br><b>Acute Myocardial Infarction</b><br>IMMEDIATE CAUSE (a):<br><b>410 -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b):<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c):  |  |   |  |   |  |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):   |  |   |  |   |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                         |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19               |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Sept. 22, 1980</b> to <b>Sept. 22, 1980</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Sept. 22, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death. |  |   |  |   |  |  |   |   |  |  |
| 22b. SIGNATURE<br><i>Maurice B. Furlong</i>   |  |   | DEGREE<br><b>M.D.</b>  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   | 22c. DATE SIGNED<br><b>Sept. 22, 1980</b>        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Maurice B. Furlong, M.D.</b>  |  |   | 22e. ADDRESS<br><b>7620 York Rd. Towson, Md. 21204</b>                   |   |  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  |   | 23b. DATE<br><b>Sept. 23, 1980</b>                                       |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Crematory</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>   |  |   | ADDRESS<br><b>Towson, Md. 21204</b>                                      |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 24 1980</b>  |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

12 2 8 0



*Handwritten signature or text, possibly "M. J. ..."*

Wm. J. ...  
...



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |                  |                  |  |  |   |   |   |                               |  |                               |   |                                |   |            |   |  |   |          |  |              |              |  |                        |                        |  |  |
|--|--|------------------|------------------|--|--|---|---|---|-------------------------------|--|-------------------------------|---|--------------------------------|---|------------|---|--|---|----------|--|--------------|--------------|--|------------------------|------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  | FIRST<br>Charles |  |  | MIDDLE<br>D.  |   |   | LAST<br>Hill                  |  |                               | 2a. DATE KNOWN<br>OF DEATH<br>ESTIMATED   |                                |   | MONTH<br>9 |   |  | DAY<br>30                                       |          |  | YEAR<br>1980 |              |  | 2b. HOUR<br>M<br>12:10 |                        |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White |                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 30, 1951   |  |   | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>29 YRS. |   | IF UNDER 1 YR.<br>MONTHS DAYS |  | IF UNDER 24 HRS.<br>HOURS MIN |   | 2c. DATE<br>PRONOUNCED<br>DEAD |   |            | MONTH<br>10   |  |   | DAY<br>3 |  |              | YEAR<br>1980 |  |                        | 2d. HOUR<br>M<br>12:10 |  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Maryland   |  |                  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                               |  |                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |                                |   |            |   |  |   |          |  |              |              |  |                        |                        |  |  |
| 10. CITY OR TOWN OF DEATH<br>Woodlawn  |  |                  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3618 Yennar Lane |  |   |   |   |                               |  |                               |   |                                |   |            | 12a. USUAL OCCUPATION (TYPE OF WORK<br>OR VARIOUS WORKS OF LIFE)<br>President |  |   |          | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br>Construction |              |              |  |                        |                        |  |  |
| 13a. STATE<br>Maryland   |  |                  |                  | 13b. COUNTY<br>Baltimore   |  |   |   | 13c. CITY OR TOWN<br>Woodlawn   |                               |  |                               | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                | 13e. STREET ADDRESS<br>3618 Yennar Lane Apt. 1 B                                    |            |   |  |   |          |  |              |              |  |                        |                        |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Vernon Hill  |  |                  |                  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rachael Cowden |   |   |                               |  |                               |   |                                |   |            |   |  |   |          |  |              |              |  |                        |                        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                  |                  | 16b. SOCIAL SECURITY NO.<br>523-66-5486  |  |   |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Barbara B. Hill 707 Sawyer Court   |                               |  |                               |   |                                |   |            |   |  |   |          |  |              |              |  |                        |                        |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gunshot wound of Head (Rifle)</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br><u>9552</u><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |  |                  |                  |  |  |   |   |   |                               |  |                               |   |                                |   |            |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |          |  |              |              |  |                        |                        |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |                  |  |  |   |   |   |                               |  |                               |   |                                |   |            |   |  |   |          |  |              |              |  |                        |                        |  |  |
| 19a. DATE OF OPERATION   |  |                  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |   |   |                               |  |                               |   |                                | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |            |   |  |   |          |  |              |              |  |                        |                        |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>12:10 9 30 1980   |  |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject shot himself   |                               |  |                               |   |                                |   |            |   |  |   |          |  |              |              |  |                        |                        |  |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK   |  |                  |                  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>home   |  |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>3618 Yennar Lane, Woodlawn, Baltimore Co., Md.   |                               |  |                               |   |                                |   |            |   |  |   |          |  |              |              |  |                        |                        |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |                  |  |  |   |   |   |                               |  |                               |   |                                |   |            |   |  |   |          |  |              |              |  |                        |                        |  |  |
| ACTUAL<br>SIGNATURE<br><u>Margarita A. Korell</u>  |  |                  |                  | M.D.<br>Assistant  |  |   |   | MEDICAL EXAMINER  |                               |  |                               | DATE<br>SIGNED<br>10-3-80   |                                |   |            |   |  |   |          |  |              |              |  |                        |                        |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Margarita A. Korell, M.D.  |  |                  |                  | ADDRESS<br>111 Penn Street   |  |   |   |   |                               |  |                               |   |                                |   |            |   |  |   |          |  |              |              |  |                        |                        |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                  |                  | 23b. DATE<br>10-6-1980   |  |   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley  |                               |  |                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cockeysville Maryland                             |                                |   |            |   |  |   |          |  |              |              |  |                        |                        |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc.   |  |                  |                  | ADDRESS<br>1050 York Road<br>Towson, Maryland  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 6 1980   |                               |  |                               | 25b. REGISTRAR'S SIGNATURE<br><u>Robert Helms</u>   |                                |   |            |   |  |   |          |  |              |              |  |                        |                        |  |  |



UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

TO : DIRECTOR, FBI (100-3-10)  
FROM : SAC, NEW YORK (100-3-10)  
SUBJECT: [Illegible]

Re New York letter to Bureau dated 10-1-60.  
Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated and captioned as above.  
The LHM is being furnished to the New York Office for its information and for its use in the event of a future investigation of the subject matter.

Very truly yours,  
[Illegible Signature]  
Special Agent in Charge

Enclosure  
100-3-10  
100-3-10

100-3-10  
100-3-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 22181

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Norma Maxine HILPERT   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>September 19, 1980              |   |  | 2b. HOUR<br>4:40 P.M.  |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 9, 1912   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ill.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| 13a. STATE<br>Md.   |  |   | 13b. COUNTY<br>Howard  |   | 13c. CITY OR TOWN<br>Sykesville                          |  | 13d. STREET ADDRESS<br>14306 Old Frederick Rd.                       |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frederick Lovins  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Winnie Baker          |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>532260235   |   | 17. INFORMANT<br>Max Hilpert                             |  | ADDRESS<br>Sykesville, Md.   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Cardiopulmonary Arrest<br>7110<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Septic Arthritis, Liver Failure, Bleeding<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(c) Esophageal Varices |  |   |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that X (this hospital) attended the deceased from September 2, 1980, to September 19, 1980, that I (we) last saw the deceased alive on September 19, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, X (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Chy   |  |   |  |   | DEGREE   |  | 22c. DATE SIGNED<br>3/19/80  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Juliana Chyu   |  |   |  |   | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237          |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>9-22-80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Lake View Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Sykesville Carroll Md. |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Harry W. Haight   |  |   |  |   | ADDRESS<br>Sykesville, Md.                               |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 24 1980                         |  | 25b. REGISTRAR'S SIGNATURE<br>notary         |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 80 22182   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>HOLST, ETHEL M. HOLST   |  |   |  | 2b. HOUR 0235 M   |  |   |  |
| 3 SEX Female  |  | 4 RACE White  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>Feb. 18, 1894   |  | 6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS.  |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.   |  | 7c. CITIZEN OF WHAT COUNTRY? USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH Balto. Co. MD.  |  |
| 10 CITY OR TOWN OF DEATH Randallstown   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore Co. Hospt. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife   |  | 12b. KIND OF BUSINESS OR INDUSTRY Home  |  |
| 13a. STATE Neb.   |  |   |  | 13b. COUNTY 68005   |  | 13c. CITY Bellevue  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST George T. Duvall   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Dixon  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO  |  |   |  | 16b. SOCIAL SECURITY NO. 505-01-6210  |  | 17 INFORMANT ADDRESS Ethel Davis Hampstead, Md. 21074   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest. (b) Gastrointestinal bleeding. (c) Cerebrovascular Accident. 436-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost <sup>saw</sup> the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                    |  |   |  |   |  |   |  |
| 22b. SIGNATURE Hafeez A Syed MD   |  |   |  | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED 9/14/80  |  |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT) HAFEEZ A SYED MD  |  |   |  | 22a. ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE Sept. 18, 80  |  | 23c. NAME OF CEMETERY OR CREMATORY Bellevue Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Bellevue Neb. 68005   |  |
| 24 FUNERAL DIRECTOR NAME Eline Funeral Home Hampstead, Md. 21074  |  |   |  | 25a. DATE OF DEATH BY REGISTRATION SEP 22 1980  |  | 25b. REGISTRAR'S SIGNATURE  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 0 2 2 1 8 3<br>REG. NO.   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |  | 2b. HOUR  |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>CHRISTIAN G. HOOVER   |  |  |  | September 13, 1980  |  |  |  | M   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>December 16, 1902   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Ruxton   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Manor Care - Ruxton |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mechanic   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Harvester   |  |
| 13a. STATE<br>Maryland  |  |  |  | 13b. CITY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Lutherville   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  |
| 14. FATHER'S NAME<br>Thomas Love Hoover   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>Ada L. Crouse   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |  |  | 16b. SOCIAL SECURITY NO.<br>217-03-3373A  |  | 17. INFORMANT ADDRESS<br>Mrs. S. Mildred Hoover 36 Cavan Drive                 |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CVA<br>4292 DUE TO, OR AS A CONSEQUENCE OF<br>(b) Hypertension<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) ASCVD<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 mos<br>10 yrs |  |  |  |   |  |  |  | 18b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |
|   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/20/62 to 9/13/80, that (I) (we) lost the deceased alive on 8/31/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                 |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>George T. Gilmore M.D.  |  |  |  | 22c. DATE SIGNED<br>9/15/80   |  |  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>George T. Gilmore, M.D.  |  |
| 22e. ADDRESS<br>1717 York Road, Lutherville, Md.  |  |  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  |  | 23b. DATE<br>9-16-1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Carmel Church Cem                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Parkton Maryland  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc. Towson, Maryland   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 16 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>Ricky McCreedy                                   |  |   |  |





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4920  
 BP  
 DHMH - 16 50M 1/76  
 (VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |   |   |  |   |
|---|--|---|--|---|--|---|---|--|---|
| 1 - FOR STATE REGISTRAR<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |   |  |   |
| REG. NO. 8 0 2 2 1 8 4  |  |   |  |   |  |   |   |  |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Jennie K. Horky  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>September 3, 1980  |   | 2b. HOUR<br>8:10 AM                       |  |   |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>4-10-1896  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto. Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |   |  |   |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph's Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Home Maker                     |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |   |  |   |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br>2318 Foster Ave.-21234  |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>May  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Unknown  |   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  |   |  | 16b. SOCIAL SECURITY NO.<br>212-10-2096   |  | 17. INFORMANT ADDRESS<br>Mrs. Anna M. Doty - 2318 Foster Avenue 21234                           |   |  |   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Azotemia and renal failure<br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Chronic nephrosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) disease. Cerebrovascular thrombosis<br>Arteriosclerotic cardiovascular |  |   |  |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>? |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |  |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |   |  |   |
| 22a. I certify that (this hospital) attended the deceased from August 30, 19 80, to September 3, 19 80, that (we) last saw the deceased alive on September 3, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.                         |  |   |  |   |  |   |   |  |   |
| 22b. SIGNATURE<br>Abdohamid Ghiladi, M.D.   |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br>9-3-80   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Abdohamid Ghiladi, M.D.  |  |   |  |   | 22e. ADDRESS<br>7401 Osler Dr. Towson, Md. 21204   |   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>9-6-80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith Cemetery   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto. Md.   |   |  |   |
| 24. FUNERAL DIRECTOR NAME<br>John C. Miller Inc-6415 Belair Rd.-21206   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>SEP 5 1980  |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature] |  |   |



TO : DIRECTOR, FBI (100-371100)  
FROM : SAC, NEW YORK (100-100000)  
SUBJECT: [Illegible]  
RE: [Illegible]  
DATE: 10-1-68  
CLASS: [Illegible]  
EXTENSION: [Illegible]  
100-371100-100000

[Extremely faint and illegible body text, possibly containing a memorandum format with sections like TO, FROM, SUBJECT, and RE.]

TO HOSPITAL/WORK ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 1 8 5

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |   |  |   |   |   |  |
|--|--|---|--|--|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Edwin S Howe Sr.  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9 1 1980                        |  |   | 2b. HOUR<br>6:45 P.M.  |   |   |   |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 7 1901   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.Y.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |   |   |   |  |
| 10 CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Multi Medical Centre |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret Traffic Mgr  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Oil  |   |  |
| 13a. STATE<br>Md.  |  |   | 13b. COUNTY<br>Balto   |  | 13c. CITY OR TOWN<br>Towson                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br>8402 Charles Valley Ct |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Howe  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary  |   |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216 03 9901 |  | 17 INFORMANT<br>ADDRESS<br>Catherine V. Howe Same         |  |   |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c).<br>PART I. DEATH WAS CAUSED BY: <i>Prob Septic process from GU tract</i><br>IMMEDIATE CAUSE (a) <i>33220</i>   |  |   |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>12 HR  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>1b) <i>Urinary retention, chronic catheterization</i>  |  |   |  |  |   |  |   | 1 MO.   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>1c) <i>Parkinson's Disease, Prostatic hypertrophy</i>  |  |   |  |  |   |  |   | 10 YR   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 11a)<br><i>Squamous cell carcinoma of lung, Sideroblastic anemia</i>   |  |   |  |  |   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6/17</i> , 19 <i>80</i> , to <i>7-1</i> , 19 <i>80</i> , that (I) (we) lost<br>saw the deceased alive on <i>9/1</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |  |   |   |   |  |
| 22b. SIGNATURE<br><i>John A. Nesbitt</i> MD  |  |   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>9/3/80  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John A. Nesbitt 3rd   |  |   |  |  |   | 22e. ADDRESS<br>201 E. University Pkw  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   | 23b. DATE<br>9/4/1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Mem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cockeysville Balto Md                             |   |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home 6500 York Rd.   |  |   |  |  |   | 25a. DATE RECEIVED BY REGISTRAR<br>SEP 8 1980  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |   |  |



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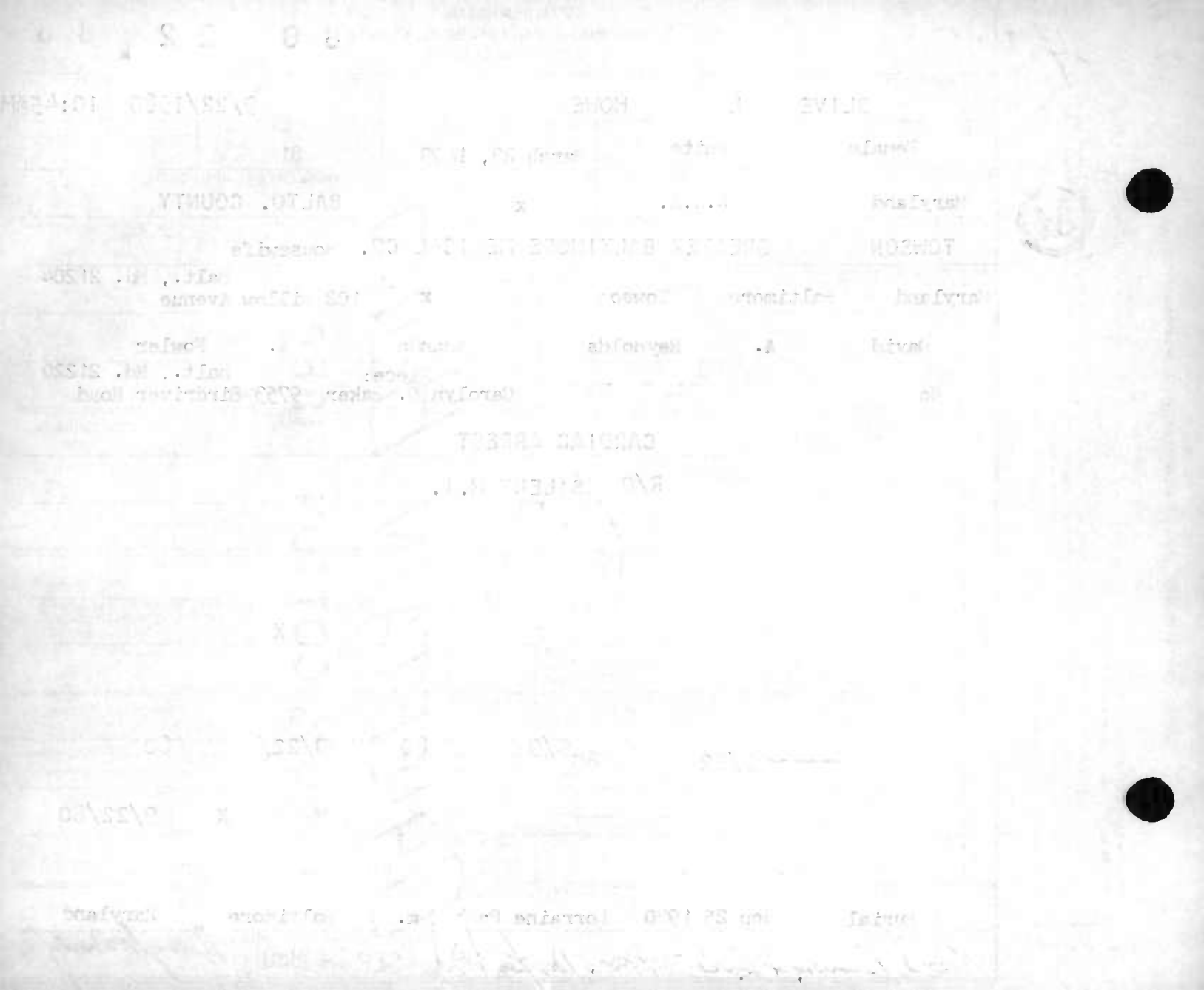
Salisbury County

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Registrar. Pages 3 and 4 should be filed in the office of the State Health Department. Pages 5 and 6 should be filed in the office of the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |                                 |   |   |   |  |  |  | 8 0 2 2 1 8 6   |  |
|--|--|---|---------------------------------|---|---|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |                                 |   |   |   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>OLIVE L HOWE</b>   |  |   |                                 |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9/22/1980</b>   |  | 2b. HOUR<br><b>10:45AM</b>   |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 23, 1899</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. COUNTY</b> MD                                 |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN SUCH CITY, GIVE STREET ADDRESS)<br><b>GREATER BALTIMORE MEDICAL CR.</b> |                                 |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   |                                 |   |   | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Towson</b>   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>David A. Reynolds</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Amanda A. Fowler</b>  |                                 |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-74-3796</b>   |                                 | 17. INFORMANT<br><b>Niece:</b><br><b>Carolyn O. Baker</b>   |   | ADDRESS <b>Balt., Md. 21220</b><br><b>9753 Birdriver Road</b>                                   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>CARDIAC ARREST</b><br>IMMEDIATE CAUSE (a)<br><b>4275 R/O SILENT M.I.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |                                 |   |   |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |                                 |   |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   |                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |                                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/9</b> , 19 <b>80</b> , to <b>9/22/</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>9/22</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |                                 |   |   |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Mohammed Tabbaa</b>   |  |   |                                 |   |   | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>9/22/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mohammed Tabbaa, M.D.</b>  |  |   |                                 |   |   | 22e. ADDRESS<br><b>6701 N. Charles St., Baltimore, MD 21204</b>                                 |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>Sep 25 1980</b> |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cem.</b> |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc.</b>   |  |   |                                 |   |   | 24b. ADDRESS<br><b>Baltimore, Maryland</b>  |  | 24a. DATE REC'D. BY REGISTRAR<br><b>SEP 24 1980</b>  |  | 24c. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 1 8 7

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |   |   |  |  |  |
|--|--|---|---|---|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Joseph Francis Hrubes</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 3 80</b>                              |   |  | 2b. HOUR<br><b>± 3 A.M.</b>   |   |  |  |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>white</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 7, 1894</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Middle River</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>820 Chester Road</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ironworker</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>   |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Middle River</b>                         |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>820 Chester Road 21220</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank - Hrubes</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Johanna - Krantz</b>          |   |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWI 212 18 3220</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Imelda Hrubes, wife Same</b>      |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Natural Causes</b><br><b>79999</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>NA</b>  |  |  |
|  |  |   |   |   |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>None</b>  |  |   |   |   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>None</b>  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                        |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)            |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>1975</b> , 19____, to <b>9-3-80</b> , 19____, that (1) (we) last saw the deceased alive on <b>Aug 1980</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.                  |  |   |   |   |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>B. J. Yukna</b>   |  |   | DEGREE<br><b>MD, FAAFP</b>  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>9/3/80</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Bernard J. Yukna, MD, FAAFP</b>  |  |   | 22e. ADDRESS<br><b>404 Bowleys Quarters Rd/Balto.MD/21220</b>                     |   |  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>9-5-80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill Cemetery</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore County, Maryland</b>                 |  |  |  |
| 24. FUNERAL HOME<br><b>Brudzinski Funeral Home</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 4 1980</b>                                |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>   |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.







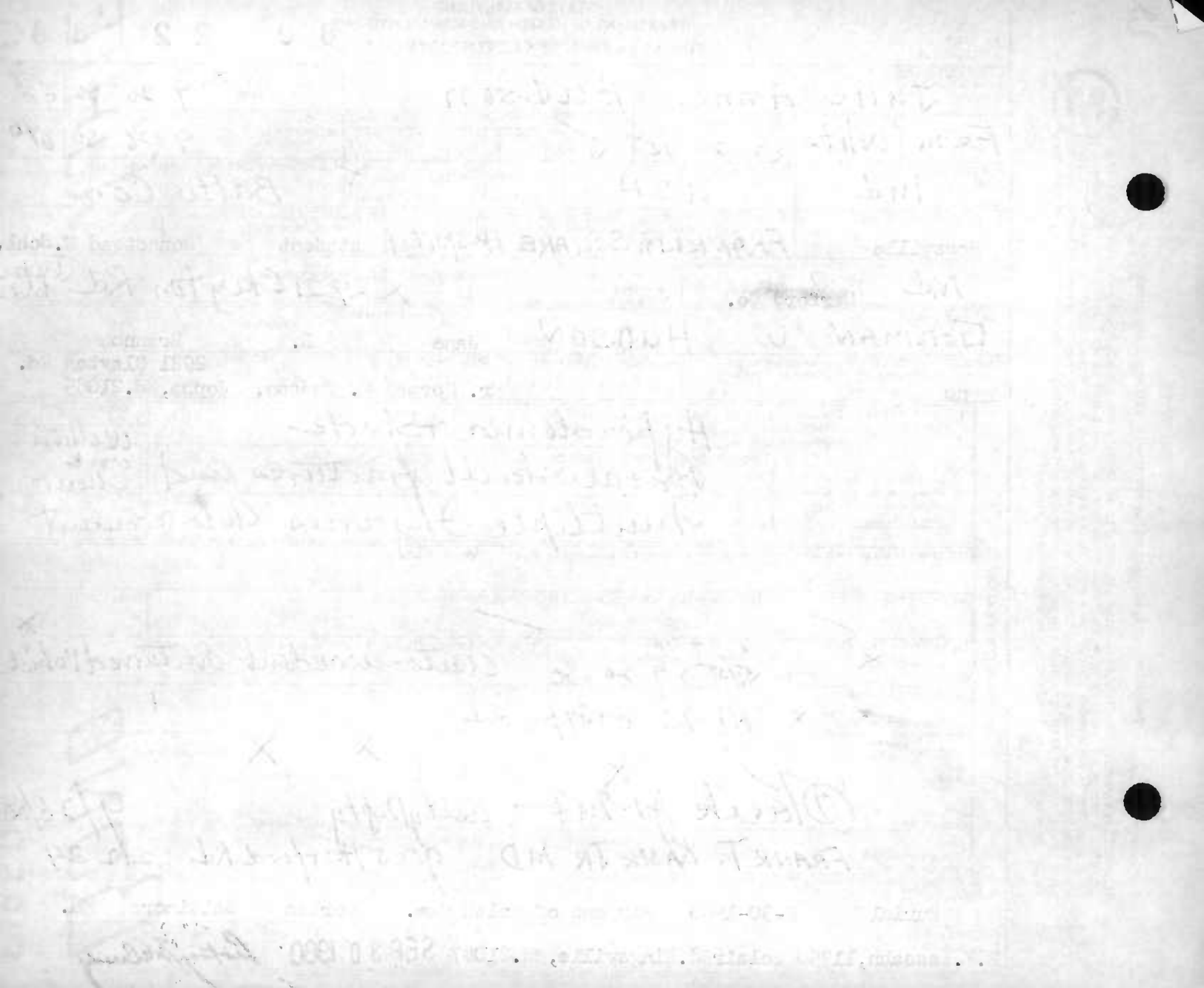
FOR  
STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 0 2 2 1 8 3

|  |  |  |  |   |
|--|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Julie Anne Hudson</b>   |  | 2a. DATE KNOWN OF DEATH<br>MONTH <input checked="" type="checkbox"/> 9 DAY 26 YEAR 1980  |  | 2b. HOUR<br>6:50 PM   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH 3 DAY 26 YEAR 1975   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY 5 YRS.                                  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto Co.</b> MD                |   |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SQUARE Hospital</b> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>student</b>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Homestead W. Sch.</b>              |   |
| 13a. STATE<br><b>MD</b>  | 13b. CITY OR TOWN<br><b>HARFORD Co.</b>  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 13d. STREET ADDRESS<br><b>2921 Clayton Rd Joppa Md</b>                     |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GORMAN W. HUDSON</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Jane L. Brannon</b>  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>Mr. Gorman W. Hudson, Joppa, Md. 21085</b>  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypovolemia + Shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Basal Skull fractures and</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Multiple Injuries Auto accident</b>   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>within one hour</b>              |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5:15 P.M. 9 26 1980</b>  |  |   |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Auto accident overturned vehicle</b>   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                     |  |   |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>RT 95 So + Joppa Rd.</b>   |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Accident</b> <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |   |
| ACTUAL SIGNATURE<br><b>Frank T. Kasik Jr MD</b>  |  | DATE SIGNED<br><b>9/26/80</b>  |  |   |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>FRANK T. KASIK JR MD</b>   |  | ADDRESS<br><b>9005 Harford Rd 21234</b>  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>9-30-1980</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cem.</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Overlea Baltimore Md.</b> |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 30 1980</b>  |  |   |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><b>L. H. H. H.</b>   |  |   |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, PAGES 4, 5, AND 6 TO THE CHIEF MEDICAL EXAMINER, AND PAGES 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 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600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |  | 6. AGE (IN YEARS LAST BIRTHDAY) |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) |  | 7b. CITIZEN OF WHAT COUNTRY?      |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH          |  |
|---|--|---|--|--|--|--|--|---------------------------------|--|---|--|-----------------------------------|--|---|--|---|--|
| AKA Ella Blanche McBee Hughes<br>ELLA Blanche HUGHES  |  | Female  |  | White  |  | April 17, 1885   |  | 95 YRS.                         |  | Penna                                     |  | U.S.A.                            |  |   |  | Baltimore County MD.                          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                                 |  | Randallstown                              |  | Baltimore County General Hospital |  | Housewife   |  | Own Home                                      |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  | 13e. STREET ADDRESS             |  | Maryland                                  |  | Baltimore                         |  | Owings Mill   |  | 16 Wengate Rd.                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS           |  | Ephraim F. Herr                           |  | Mary Jane Hoffman                 |  | No  |  | 178-16-0491 Mrs. Clyde Knipple 17606 Cool Rd. |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u><br><u>4140</u> DUE TO, OR AS A CONSEQUENCE OF <u>with heart failure chronic</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |   |  |  |  |  |  |                                 |  |   |  |                                   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes Mellitus</u>  |  |   |  |  |  |  |  |                                 |  |   |  |                                   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                 |  |   |  |                                   |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |                                 |  |   |  |                                   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |                                 |  |   |  |                                   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-12-1980</u> , to <u>9-30-1980</u> , that (I) (we) lost saw the deceased alive on <u>9-30-1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |                                 |  |   |  |                                   |  |   |  |   |  |
| 22b. SIGNATURE  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED   |  |                                 |  |   |  |                                   |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |  |  |  |  |                                 |  |   |  |                                   |  |   |  |   |  |
| Soonchal Hong   |  | Baltimore County General Hospital   |  |  |  |  |  |                                 |  |   |  |                                   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |                                 |  |   |  |                                   |  |   |  |   |  |
| Burial  |  | Oct 3, 1980   |  | Mt. View Cemetery  |  | Harney Carroll Co., Md.  |  |                                 |  |   |  |                                   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR NAME   |  | 24a. CITY OR TOWN   |  | 24b. DATE REC'D. BY REGISTRAR  |  | 24c. REGISTRAR'S SIGNATURE   |  |                                 |  |   |  |                                   |  |   |  |   |  |
| Skiles Funeral Home   |  | Taneytown, Md. 21787  |  | OCT 6 1980   |  | [Signature]  |  |                                 |  |   |  |                                   |  |   |  |   |  |
| 136 E. Balto. St.,  |  |   |  |  |  |  |  |                                 |  |   |  |                                   |  |   |  |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 AND 2 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME 5)  
15M 7/76

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                                 |   |   |  |  |  |                            |   |   |   |  |
|--|---------------------------------|---|---|--|--|--|----------------------------|---|---|---|--|
| <div> <div>FOR<br/>1- STATE<br/>REGISTRAR</div> <div> <div>REG. NO.</div> <div>70 22190</div> </div> </div>  |                                 |   |   |  |  |  |                            |   |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Robert J. Huppman</b>  |                                 |   |   |  |  |  |                            |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br><input checked="" type="checkbox"/> 9 8 19 80<br><input type="checkbox"/> 9 8 19 80 |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 6, 1912</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>68 YRS.</b>  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN                                | IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>9 8 19 80</b> | 7d. HOUR<br><b>3:00 PM</b> |   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>   |                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>                 |  |                            |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |                                 | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>108 S. Prospect Avenue</b>                 |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Metallurgist</b> |  |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Koppers Co.</b>                             |   |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                                 |   |   |  |  |  |                            |   |   |   |  |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>Baltimore</b> | 13c. CITY OR TOWN<br><b>Catonsville</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>108 S. Prospect Ave. 21228</b>               |  |  |                            |   |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Huppman</b>   |                                 |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Matilda Wagner</b> |  |  |                            |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                                 |   |   | 16b. SOCIAL SECURITY NO.<br><b>---</b>                                 |  |  |                            | 17. INFORMANT<br>ADDRESS<br><b>Veronica Huppman 91 Summit Ave. New Jersey</b>       |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |                                 |   |   |  |  |  |                            |   |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                                 |   |   |  |  |  |                            |   |   |   |  |
| 19a. DATE OF OPERATION   |                                 |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                      |  |  |                            | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                                 |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  |                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)       |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                                 |   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)            |  |  |                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                 |   |   |  |  |  |                            |   |   |   |  |
| ACTUAL SIGNATURE<br><b>Virginia L. Dolan</b>   |                                 |   |   | TITLE (SPECIFY)<br><b>Assistant</b>                                    |  |  |                            | DATE SIGNED<br><b>9/9/80</b>  |   |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>   |                                 |   |   | ADDRESS<br><b>111 Penn Street</b>                                      |  |  |                            |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                                 |   |   | 23b. DATE<br><b>Sept. 12, 1980</b>                                     |  |  |                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St Philip &amp; James</b>                  |   |   |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Phillipsburg, New Jersey</b>   |                                 |   |   | 23e. DATE REC'D. BY REGISTRAR<br><b>SEP 16 1980</b>                    |  |  |                            | 23f. REGISTRAR'S SIGNATURE<br><b>Richard McCreedy</b>                               |   |   |  |

FUNERAL DIRECTOR

Bruzdzinski Funeral Home PA 1407 Old Eastern Ave



Extremely faint, illegible text covering the entire page, likely bleed-through from the reverse side. Some fragments are visible, such as "MAY 1964" and "RECEIVED".



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |   |  |  |   |  |  |  |
|---|--|--|---|---|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |   |   |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>ANTONIETTA Antoinette Impaciadore</b>  |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Sept. 24, 1980</b>  |  | 2b. HOUR<br><b>12:30am</b>  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>March 6, 1900</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Italy</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>    |   | 12b. KIND OF BUSINESS, OR INDUSTRY   |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>                                     |   | 13c. CITY OR TOWN<br><b>Towson</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1204 Dulaney Valley Road</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Gabriele Colluci</b>  |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Concetta DeLuca</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>177-14-1898D</b>                     |   | 17. INFORMANT ADDRESS<br><b>Mrs. Lucy I. Bickford 1204 Dulaney Valley Road</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>Acute myocardial infarction</b><br>IMMEDIATE CAUSE (a) <b>Cardiogenic shock</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br><b>Arteriosclerotic cardiovascular heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Arteriosclerotic cardiovascular heart disease</b><br>(c)             |  |  |   |   |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Sept. 23, 1980</b> to <b>Sept. 24, 1980</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Sept. 24, 1980</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (I/we) (did) (do not) view the body after death. |  |  |   |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Nestor Carmona</i>   |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>Sept. 24, 1980</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Nestor Carmona, M.D.</b>  |  |  |   |   | 22e. ADDRESS<br><b>6012 Harford Rd., Baltimore, Md. 21214</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>9-27-1980</b>                                       |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Most Holy Redeemer</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                            |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Ruck Towson Funeral Home, Inc. Towson, Maryland</b>   |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 25 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

MEDICAL CERTIFICATION

29

490



to the following information

of the following nature

of the following nature



Items #18a-22a Film G548 10/23/80 STATE OF MARYLAND  
 FOR  
 1- STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 REGISTRAR MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 0 2 2 1 9 2

|   |  |  |   |  |  |   |  |  |                                   |  |  |                                      |  |  |
|---|--|--|---|--|--|---|--|--|-----------------------------------|--|--|--------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST MIDDLE LAST   |  |  | 2a. DATE KNOWN OF DEATH   |  |  | ESTIMATED MONTH DAY YEAR          |  |  | 2b. HOUR                             |  |  |
| Richard William Insley  |  |  |   |  |  | 2a. DATE KNOWN OF DEATH   |  |  | ESTIMATED MONTH DAY YEAR          |  |  | 2b. HOUR                             |  |  |
| SEX   |  |  | 4. RACE   |  |  | 5. DATE OF BIRTH  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |  | IF UNDER 1 YR. IF UNDER 24 HRS       |  |  |
| Male  |  |  | White   |  |  | 5 31 1957   |  |  | 23 YRS.                           |  |  | MONTHS DAYS HOURS MIN                |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8. MARRIED  |  |  | NEVER MARRIED                     |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |
| Maryland  |  |  | U. S. A.  |  |  | WIDOWED   |  |  | DIVORCED                          |  |  | Baltimore County, MD.                |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |                                      |  |  |
| Timonium  |  |  | 205 Abbey Hill Court  |  |  | Student   |  |  | xxxx                              |  |  |                                      |  |  |
| 13a. STATE  |  |  | 13b. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?  |  |  | 13e. STREET ADDRESS               |  |  |                                      |  |  |
| Maryland  |  |  | Balto.  |  |  | YES NO  |  |  | 205 Abbey Hill Court              |  |  | 21093                                |  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                  |  |  | 16b. SOCIAL SECURITY NO.          |  |  | 17. INFORMANT                        |  |  |
| Thomas Irving Insley, Sr.   |  |  | Maralee Elizabeth Moore   |  |  | No  |  |  | 216-76-8497                       |  |  | Thomas I. Insley Sr. Timonium Md.    |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |   |  |  |                                   |  |  |                                      |  |  |
| PART I DEATH WAS CAUSED BY:   |  |  |   |  |  |   |  |  |                                   |  |  |                                      |  |  |
| IMMEDIATE CAUSE (a) <u>Acute ethanol intoxication</u>   |  |  |   |  |  |   |  |  |                                   |  |  |                                      |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |  |   |  |  |                                   |  |  |                                      |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                       |  |  |   |  |  |   |  |  |                                   |  |  |                                      |  |  |
| (b)   |  |  |   |  |  |   |  |  |                                   |  |  |                                      |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |  |   |  |  |                                   |  |  |                                      |  |  |
| (c)   |  |  |   |  |  |   |  |  |                                   |  |  |                                      |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |  |   |  |  |   |  |  |                                   |  |  |                                      |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  | 20. AUTOPSY?  |  |  |                                   |  |  |                                      |  |  |
|   |  |  |   |  |  | YES NO  |  |  |                                   |  |  |                                      |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  |  | 21b. TIME OF INJURY   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |                                   |  |  |                                      |  |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR  |  |  |   |  |  |                                   |  |  |                                      |  |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  | 21f. LOCATION   |  |  |                                   |  |  |                                      |  |  |
| WHILE AT WORK NOT WHILE AT WORK   |  |  |   |  |  | STREET CITY OR TOWN COUNTY STATE  |  |  |                                   |  |  |                                      |  |  |
| 22a. I certify that I took charge of the remains described above, held on   |  |  | Autopsy Inspection Inquiry and in my opinion  |  |  |   |  |  |                                   |  |  |                                      |  |  |
| death resulted from   |  |  | Natural causes Accidents Suicide Homicide Undetermined manner   |  |  |   |  |  |                                   |  |  |                                      |  |  |
| ACTUAL SIGNATURE  |  |  | TITLE (SPECIFY)   |  |  | DATE  |  |  |                                   |  |  |                                      |  |  |
| Thomas D. Smith   |  |  | Deputy Chief  |  |  | 9/22/80   |  |  |                                   |  |  |                                      |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |  | ADDRESS   |  |  |   |  |  |                                   |  |  |                                      |  |  |
| Thomas D. Smith, M.D.   |  |  | 111 Penn Street   |  |  |   |  |  |                                   |  |  |                                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE   |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION                     |  |  |                                      |  |  |
| Burial  |  |  | 9/26/80   |  |  | Washington Cemetery   |  |  | Hurlock Dorchester Md.            |  |  |                                      |  |  |
| 24. FUNERAL DIRECTOR  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |                                   |  |  |                                      |  |  |
| NAME ADDRESS  |  |  | SEP 30 1980   |  |  | Rafael A. Bandy   |  |  |                                   |  |  |                                      |  |  |
| Martin D. Lawson 10 W. Padonia Road   |  |  |   |  |  |   |  |  |                                   |  |  |                                      |  |  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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MEDICAL CERTIFICATION

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 1 9 3

REG. NO.

|   |  |   |  |  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>WILLIAM G. JACKSON  |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>9-9-80 |  |  | 2b HOUR<br>8:45 PM   |  |  |  |
| 3 SEX<br>MALE   |  | 4 RACE<br>BLACK   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>12 6 08   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS   |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTIMORE   |  | 7b CITIZENSHIP<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>REISTERSTOWN  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BENT NURSING HOME |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SEXTON                      |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b STATE<br>BALTIMORE   |  |   |  | 13c CITY OR TOWN<br>BALTO  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>LEWIS JACKSON  |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MAGGIE BRITTON   |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>313-28-4403  |  | 17 INFORMANT<br>ADDRESS<br>MATTIE JACKSON 801 E. COLDSRING LANE  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) 1889 Chronic urinary bladder<br>DUE TO, OR AS A CONSEQUENCE OF (b) with metastasis<br>DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis                             |  |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>Years<br>Years  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from 8-27-80, to 9-9-80, that (I) (we) last saw the deceased alive on 9-8-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |  |  |
| 27b SIGNATURE<br>C.E. McWilliams M.D.   |  |   |  |  |  |  |  | 27c DATE SIGNED<br>9-9-80  |  |
| 27d PHYSICIAN'S NAME (TYPE OR PRINT)<br>C.E. McWilliams M.D.  |  |   |  | 27e ADDRESS<br>11904 Reisterstown Rd Reisterstown Md. 21136  |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b DATE<br>9/13/80   |  | 23c NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Pk.  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus, Md. /                                    |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H   |  |   |  | ADDRESS<br>1101 E. North Ave.  |  | 25a DATE REC'D. BY REGISTRAR<br>SEP 11 1980  |  | 25b REGISTRAR'S SIGNATURE<br>Robert McReady  |  |

BP  
DHMH-16 25M  
(VRA 15, 4) 1/79

29 55 80 33 2

M



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8022194

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |  |   |   |   |  |   |  |
|---|--|--|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Clara Januszak</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 3, 1980</b>          |  |   | 2b. HOUR<br><b>10:30 AM</b>   |   |  |   |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 6, 1896</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.                                      |   | 7a. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>                   |   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Armcast Nursing Home</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Home Maker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Phoenix</b>                                   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>4313 Green Glade Road</b>           |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jacob Wozniak</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Kapela</b> |  |   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>071-07-6531</b>                           |  | 17 INFORMANT ADDRESS<br><b>Amigone Funeral Home 1250 Delavan Ave.</b> |   |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>410 - Acute Myocardial Infarction Sudden</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>5+ yrs</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5+ yrs</b> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                         |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19               |  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)     |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |   |  |   |  |
| 22a. I certify that (I) (was hospital) attended the deceased from <b>18 April 1980</b> to <b>3 September 1980</b> , that (I) (was) lost saw the deceased alive on <b>1 September 1980</b> , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |  |   |   |   |  |   |  |
| 23a. SIGNATURE<br><b>Charles F. O'Donnell, M.D.</b>   |  |  |  |  |   | DEGREE<br><b>M.D.</b>   |   | 23b. DATE SIGNED<br><b>9/5/80</b>  |   |  |
| 24. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles F. O'Donnell, M.D.</b>   |  |  |  |  |   | 25a. ADDRESS<br><b>7501 York Road Towson, Maryland</b>                                |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>Sept. 6, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cemetery</b>     |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Buffalo, New York</b>                          |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>  |  |  |  |  |   | 25b. DATE REC'D. BY REGISTRAR<br><b>SEP 9 1980</b>                                    |   | 25c. REGISTRAR'S SIGNATURE<br><b>Paul J. Kelly</b>   |   |  |

80 22 19

March 2, 1934

London

Dear Sir

Dear Sir,

Referring to

your letter of the 28th

of the 28th

of the 28th

of the 28th

of the 28th

of the 28th

of the 28th

of the 28th

of the 28th

Yours

Very truly

Yours

Yours

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

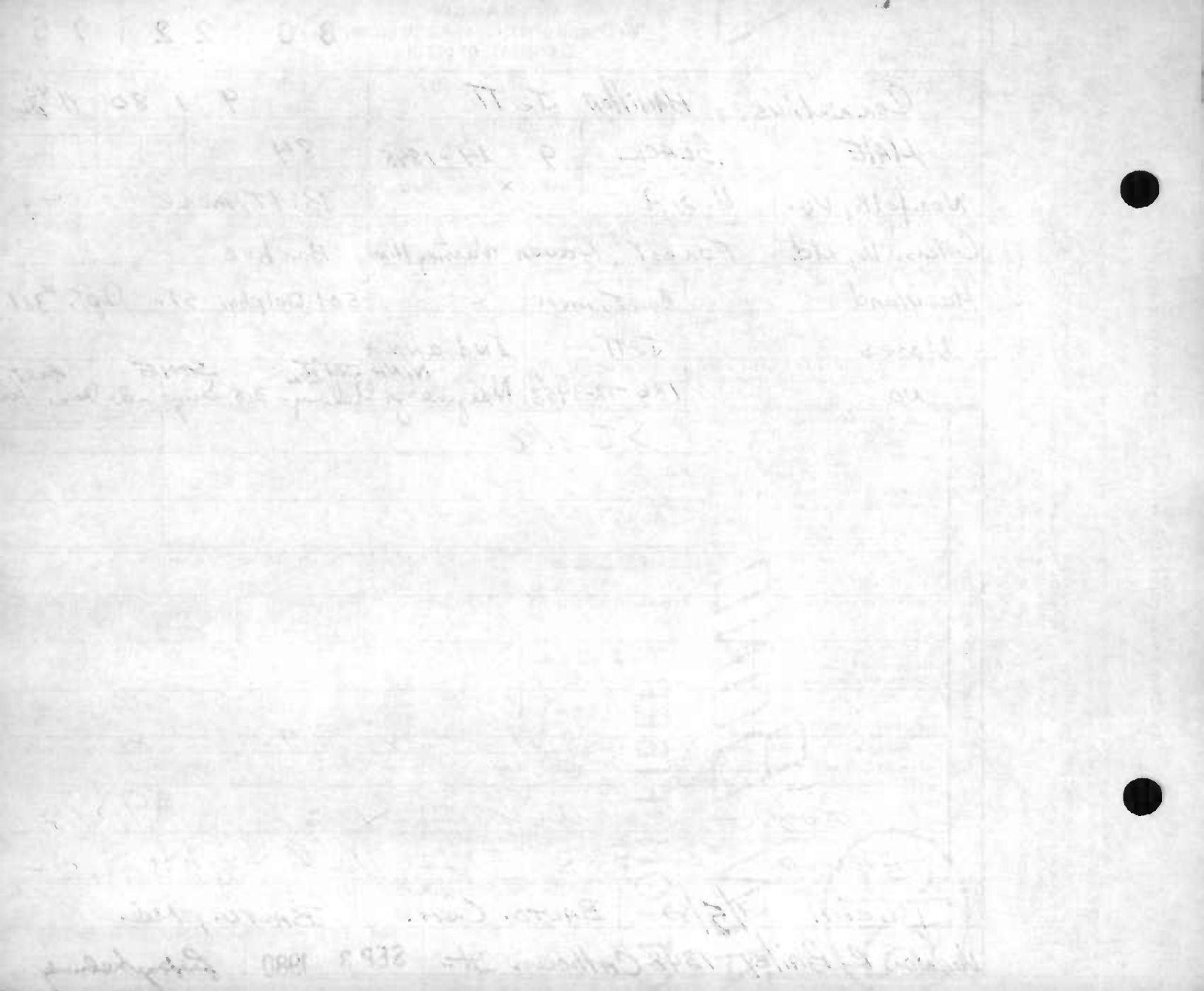
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |                              |  |  |  |                                     |  |  |  | 80               |  | 22195   |  |          |  |
|--|--|------------------------------|--|--|--|-------------------------------------|--|--|--|------------------|--|---|--|----------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |                              |  | CERTIFICATE OF DEATH   |  |                                     |  |  |  |                  |  |   |  |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                              |  | 2a. DATE OF DEATH  |  |                                     |  | MONTH  |  | DAY              |  | YEAR  |  | 2b. HOUR |  |
| Cornelius Hamilton Jett  |  |                              |  | 9  |  | 1                                   |  | 80   |  | 11               |  | 40  |  |          |  |
| 3 SEX  |  | 4 RACE                       |  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)      |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS. |  |   |  |          |  |
| MALE   |  | BLACK                        |  | 9 14-1895  |  | 84                                  |  | MONTHS   |  | DAYS             |  | HOURS   |  | MIN.     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH |  |  |  |                  |  |   |  |          |  |
| Nonfolk, Va.   |  | U. S. A.                     |  |  |  | Baltimore Co. MD.                   |  |  |  |                  |  |   |  |          |  |
| 10 CITY OR TOWN OF DEATH   |  |                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  |                                     |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |          |  |
| Catonsville, Md.   |  |                              |  | Forest Haven Nursing Home  |  |                                     |  | Barbee   |  |                  |  |   |  |          |  |
| 13a. STATE   |  |                              |  | 13b. COUNTY  |  |                                     |  | 13c. CITY OR TOWN  |  |                  |  | 13d. INSIDE CITY LIMITS?  |  |          |  |
| Maryland   |  |                              |  |  |  |                                     |  | Baltimore  |  |                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 14 FATHER'S NAME   |  |                              |  | 15. MOTHER'S MAIDEN NAME   |  |                                     |  | 13e. STREET ADDRESS  |  |                  |  |   |  |          |  |
| Moses Jett   |  |                              |  | INDIANNA   |  |                                     |  | 501 Dolphin ST. Apt. #311  |  |                  |  |   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |                              |  | 16b. SOCIAL SECURITY NO.   |  |                                     |  | 17. INFORMANT  |  |                  |  |   |  |          |  |
| NO   |  |                              |  | 136-12-3453  |  |                                     |  | NINA JETT, BALTO. Maryonie J. Halay - 315 Inlandside Ave., Balt.   |  |                  |  |   |  |          |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                              |  |  |  |                                     |  |  |  |                  |  |   |  |          |  |
| PART 1. DEATH WAS CAUSED BY:   |  |                              |  |  |  |                                     |  |  |  |                  |  |   |  |          |  |
| IMMEDIATE CAUSE (a) 436- Stroke  |  |                              |  |  |  |                                     |  |  |  |                  |  |   |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |  |                              |  |  |  |                                     |  |  |  |                  |  |   |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |                              |  |  |  |                                     |  |  |  |                  |  |   |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |                              |  |  |  |                                     |  |  |  |                  |  |   |  |          |  |
| 19a. DATE OF OPERATION   |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                                     |  | 20a. AUTOPSY?  |  |                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |          |  |
|  |  |                              |  |  |  |                                     |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |                  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |                  |  |   |  |          |  |
|  |  |                              |  |  |  |                                     |  |  |  |                  |  |   |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |                                     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |                  |  |   |  |          |  |
|  |  |                              |  |  |  |                                     |  |  |  |                  |  |   |  |          |  |
| 22. I certify that (I) (this hospital) attended the deceased from 8/21, 19 80, to 9-1, 19 80, that (I) (we) last saw the deceased alive on 8/21, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |  |  |                                     |  |  |  |                  |  |   |  |          |  |
| 22b. SIGNATURE   |  |                              |  | DEGREE   |  |                                     |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                  |  | 22c. DATE SIGNED  |  |          |  |
| HAROLD B BOB   |  |                              |  | MD   |  |                                     |  |  |  |                  |  | 9/2/80  |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |                              |  | 22e. ADDRESS   |  |                                     |  |  |  |                  |  |   |  |          |  |
| HAROLD B BOB   |  |                              |  | 7220 Park Heights Ave -  |  |                                     |  |  |  |                  |  |   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |                              |  | 23b. DATE  |  |                                     |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |          |  |
| Burial   |  |                              |  | 9/5/80   |  |                                     |  | BALTO. CEM.  |  |                  |  | BALTO., Md.   |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |                              |  | ADDRESS  |  |                                     |  | 25a. DATE REC'D. BY REGISTRAR  |  |                  |  | 25b. REGISTRAR'S SIGNATURE  |  |          |  |
| VERNON R. Bailey   |  |                              |  | 1348 Cathoun St.   |  |                                     |  | SEP 3 1980   |  |                  |  | Fitzroy Hubbard   |  |          |  |

BP







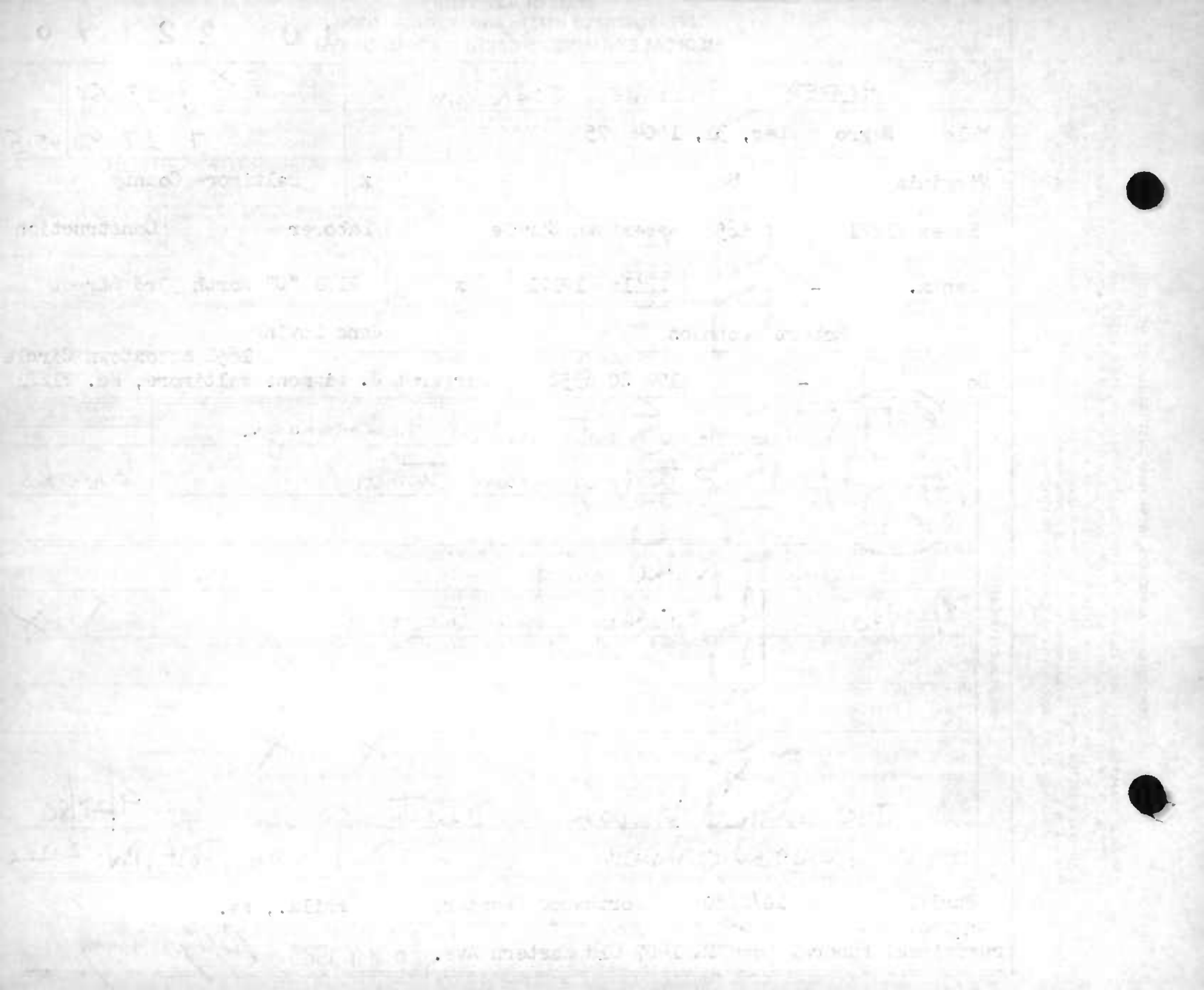
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
30M 7/73

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |  |  |  |  |  |  |  | REG. NO. 80 22196                                   |  |  |  |  |  |  |  |
|---|--|-------------------------|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |                         |  |  |  |  |  |  |  | 20. DATE KNOWN OF DEATH                             |  | 21. MONTH DAY YEAR                               |  | 22. HOUR   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ALBERT THEODORE JOHNSON</b>  |  |                         |  |  |  |  |  |  |  | 20. DATE KNOWN OF DEATH                             |  | 21. MONTH DAY YEAR                               |  | 22. HOUR   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Negro</b> |  | 5. DATE OF BIRTH<br><b>Dec, 31, 1904</b>   |  | 6. AGE (IN YEARS) LAST (THDAY) YRS.<br><b>75</b> |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN   |  | 20. DATE PRONOUNCED DEAD                            |  | 21. MONTH DAY YEAR                               |  | 22. HOUR   |  |  |  |
| 7a. BIRTHPLACE (STATE OR)   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH             |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR)<br><b>Virginia</b>  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |  |  |   |  | <b>Baltimore County</b>                          |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION                                 |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK)   |  |   |  | 12b. KIND OF BUSINESS                            |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Essex 21221</b>   |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br><b>1652 Essectown Circle</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK)<br><b>Laborer</b>   |  |   |  | 12b. KIND OF BUSINESS<br><b>Construction</b>     |  |  |  |  |  |
| 13a. STATE  |  |                         |  |  |  |  |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN                                |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS                                    |  |
| 13a. STATE<br><b>Penna.</b>   |  |                         |  |  |  |  |  |  |  | 13b. COUNTY<br><b>-</b>                             |  | 13c. CITY OR TOWN<br><b>Phila 19121</b>          |  | 13d. INSIDE CITY LIMITS?<br><b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b> |  | 13e. STREET ADDRESS<br><b>2101 C North 33rd Street</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |                         |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST          |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br><b>Robert Johnson</b>  |  |                         |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br><b>Jane Loving</b>      |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  |                         |  | 16b. SOCIAL SECURITY NO.   |  |  |  | 17. INFORMANT ADDRESS  |  |   |  | 18. ADDRESS                                      |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br><b>No</b>   |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>172 20 6352</b>   |  |  |  | 17. INFORMANT<br><b>Margaret J. Simmons Baltimore, Md. 21221</b>   |  |   |  | 18. ADDRESS<br><b>1652 Essectown Circle</b>      |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                         |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |  |  |  |  |  |  |  |
| PART I DEATH WAS CAUSED BY:   |  |                         |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <b>Acute intracerebral hemorrhage</b>   |  |                         |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                         |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |
| (b) <b>Pituitary gland tumor</b>  |  |                         |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                         |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |
| (c)   |  |                         |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |                         |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |
| <b>Carcinoma of prostate gland</b>  |  |                         |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY?   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>8/27/80</b>  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>Pituitary gland tumor</b>        |  |  |  | 20. AUTOPSY?<br><b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>   |  |   |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br><b>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b>   |  |                         |  | 21b. TIME OF INJURY<br><b>P.M. 10</b>  |  |  |  | 21c. HOW INJURY OCCURRED   |  |   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                              |  |  |  | 21f. LOCATION  |  |   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br><b>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></b>  |  |                         |  | 21e. PLACE OF INJURY<br><b>STREET, FACTORY, FARM, ETC.)</b>                              |  |  |  | 21f. LOCATION<br><b>CITY OR TOWN COUNTY STATE</b>  |  |   |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>J. Crossan O'Donovan</b>  |  |                         |  | TITLE (SPECIFY) <b>Deputy</b>  |  |  |  | DATE SIGNED <b>9/27/80</b>   |  |   |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>J. CROSSAN O'DONOVAN</b>   |  |                         |  | ADDRESS <b>2112 Dundalk Ave., Balt., Md. 21222</b>                                       |  |  |  |  |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL   |  |                         |  | 23b. DATE  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |   |  | 23d. LOCATION                                    |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  |  |                         |  | 23b. DATE<br><b>10/2/80</b>  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Northwood Cemetery</b>  |  |   |  | 23d. LOCATION<br><b>Phila., Pa. COUNTY STATE</b> |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |                         |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR                       |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Bruzdinski Funeral Home</b>  |  |                         |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 30 1980</b> |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>  |  |  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 9, 13cc13E G 547 9/29/80 GB

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

22197

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |   |  |  |   |   |  |
|--|--|---|---|---|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Katharine<br/>Katherine Oliver Johnson</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9/ 22/1980</b>            |   |   | 2b. HOUR<br>M<br><b>M</b>  |  |   |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 / 16/ 1903</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>76</b>  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> County MD.  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Pikesville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Pikesville Conv. Home</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>School System</b>   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |   | 13b. CITY OR TOWN<br><b>Baltimore</b>                               |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13d. STREET ADDRESS<br><b>2551 Druid Hill Ave.</b> |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Freeman Oliver</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ada Quarles</b> |   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No.</b>   |  |   | 16b. SOCIAL SECURITY NO<br><b>214-40-4279</b> |  |
| 17. INFORMANT<br><b>Dr. Carson C. Johnson Jr.</b>  |  |   | ADDRESS<br><b>33 Washington Street</b>                              |   |   | CITY OR TOWN<br><b>Newton, Mass.</b>   |  |   | STATE<br><b>02158</b>                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Sepsis, Univ. heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>General arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 days</b><br><b>5 yrs.</b> |  |   |   |   |   |  |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Parkinson's Disease</b>  |  |   |   |   |   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET<br><b>3635 Old Court Rd</b>   |   | CITY OR TOWN<br><b>Anne Arundel Co.</b>  |  | STATE<br><b>Maryland</b>  |   |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <b>8/1/79</b> to <b>9-22</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>8/1</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                  |  |   |   |   |   |  |  |   |   |  |
| 22b. SIGNATURE<br><b>H. Gerald Oster</b>   |  |   |   | DEGREE<br><b>M.D.</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>9/26/80</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>H. Gerald Oster</b>  |  |   |   | 22e. ADDRESS<br><b>3635 Old Court Rd</b>  |   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Sept. 27/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN<br><b>Anne Arundel Co.</b>   |  | STATE<br><b>Maryland</b>  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Herbert E. Nutter</b>   |  | ADDRESS<br><b>3035 W. North Ave. Balto. Md.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 26 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |   |  |

2. 3. 1.

- 211

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |   |  |   |   |   | 8022198  |  |
|--|--|---|--|--|---|--|---|---|---|----------|--|
| 1- FOR STATE REGISTRAR   |  |   |  |  |   |  |   |   |   | REG. NO. |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>NEWTON PARKER JOHNSON   |  |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>SEPTEMBER 9, 1980  |  |   | 2b. HOUR<br>M   |   |          |  |
| 3 SEX<br>MALE  |  | 4 RACE<br>WHITE   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>MARCH 6, 1980   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>90 YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |   |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                         |   |   |   |          |  |
| 10 CITY OR TOWN OF DEATH<br>TOWSON   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>HOLLY HILL NURSING HOME |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SUPERVISOR       |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>POST OFFICE  |   |          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD. 13b. COUNTY 13c. CITY OR TOWN BALTIMORE   |  |   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>189 HOLLEN RD. 21212                           |   |   |          |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM JOHNSON   |  |   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LAURA VIRGINIA BURNS                            |  |   |   |   |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-09-7758  |  | 17 INFORMANT<br>ADDRESS<br>MRS. LOUIS A. KEMPER 2300 CHETWOOD CIR. TIMONIUM, MD.   |   |  |   |   |   |          |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 436- C V A - Recurrent<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Generalized arteriosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) 7 days<br>4 yrs                        |  |   |  |  |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br>Aortic Aneurysm   |  |   |  |  |   |  |   |   |   |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |   |   |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |   |   |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-24 1980, to Sept 9 1980, that (I) (we) last saw the deceased alive on 9-3 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |   |  |  |   |  |   |   |   |          |  |
| 22b. SIGNATURE<br>S. J. VENABLE  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |   |  |   | 22c. DATE SIGNED<br>9-10-80   |   |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS<br>7215 YORK RD.  |   |  |   |   |   |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>SEPT. 12, 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>PARKWOOD CEMETERY  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>PARKVILLE BALTIMORE MD. |   |   |          |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>MITCHELL-WIEDEFELD HOME   |  |   |  | ADDRESS<br>6500 YORK RD. 21212   |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>SEP 15 1980  |   |          |  |
| 25b. REGISTRAR'S SIGNATURE<br>R. H. H. H.  |  |   |  |  |   |  |   |   |   |          |  |



59-01-9

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 80 22199

|  |  |                                     |  |  |  |                                    |  |   |  |                                      |  |   |  |       |  |                       |  |  |  |
|--|--|-------------------------------------|--|--|--|------------------------------------|--|---|--|--------------------------------------|--|---|--|-------|--|-----------------------|--|--|--|
| 1- STATE REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT) |  | FIRST  |  | MIDDLE                             |  | LAST  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED |  | MONTH   |  | DAY   |  | YEAR                  |  | 2b. HOUR   |  |
|  |  | Woodrow                             |  |  |  |                                    |  | Johnson   |  |                                      |  | 9   |  | 8     |  | 1980                  |  | M  |  |
| 3. SEX   |  | 4. RACE                             |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY) |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.       |  | 2c. DATE PRONOUNCED DEAD  |  | MONTH |  | DAY                   |  | YEAR   |  |
| Male   |  | Black                               |  | 3 22 33  |  | 47 YRS.                            |  |   |  |                                      |  | 9   |  | 8     |  | 1980                  |  | 8:00 P M   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |                                     |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |       |  |                       |  |  |  |
| South Carolina   |  |                                     |  | USA  |  |                                    |  |   |  |                                      |  | Baltimore County, MD.   |  |       |  |                       |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |                                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |       |  |                       |  |  |  |
| Sparrows Point   |  |                                     |  | Sparrows Point Dispensary  |  |                                    |  |   |  |                                      |  |   |  |       |  |                       |  |  |  |
| 13a. STATE   |  |                                     |  | 13b. COUNTY  |  |                                    |  | 13c. CITY OR TOWN   |  |                                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |       |  | 13e. STREET ADDRESS   |  |  |  |
| Maryland   |  |                                     |  |  |  |                                    |  | Baltimore   |  |                                      |  |   |  |       |  | 1524 N. Payson Street |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |                                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  |                                    |  |   |  |                                      |  |   |  |       |  |                       |  |  |  |
| Clayton  |  |                                     |  | Johnson  |  |                                    |  | Mary  |  |                                      |  | Cooper  |  |       |  |                       |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  |                                     |  | 16b. SOCIAL SECURITY NO.   |  |                                    |  | 17. INFORMANT   |  |                                      |  | ADDRESS   |  |       |  |                       |  |  |  |
| YES  |  |                                     |  | Army   |  |                                    |  | 247-42-6478   |  |                                      |  | Emma Johnson 1524 N. Payson Street  |  |       |  |                       |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b><br>4029<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |                                     |  |  |  |                                    |  |   |  |                                      |  |   |  |       |  |                       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                                     |  |  |  |                                    |  |   |  |                                      |  |   |  |       |  |                       |  |  |  |
| 19a. DATE OF OPERATION   |  |                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |                                    |  |   |  |                                      |  |   |  |       |  |                       |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |                                      |  |   |  |       |  |                       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |                                      |  |   |  |       |  |                       |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                     |  |  |  |                                    |  |   |  |                                      |  |   |  |       |  |                       |  |  |  |
| ACTUAL SIGNATURE   |  |                                     |  | TITLE (SPECIFY)  |  |                                    |  | DATE SIGNED   |  |                                      |  |   |  |       |  |                       |  |  |  |
| Virginia L. Dolan  |  |                                     |  | Assistant  |  |                                    |  | 9/9/80  |  |                                      |  |   |  |       |  |                       |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |                                     |  | ADDRESS  |  |                                    |  |   |  |                                      |  |   |  |       |  |                       |  |  |  |
| Virginia L. Dolan, M.D.  |  |                                     |  | 111 Penn Street  |  |                                    |  |   |  |                                      |  |   |  |       |  |                       |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |                                     |  | 23b. DATE  |  |                                    |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |       |  |                       |  |  |  |
| Burial   |  |                                     |  | 9/13/80  |  |                                    |  | Baltimore Cemetery  |  |                                      |  | Baltimore, Maryland   |  |       |  |                       |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |                                     |  | ADDRESS  |  |                                    |  | 25a. DATE REC'D. BY REGISTRAR   |  |                                      |  | 25b. REGISTRAR'S SIGNATURE  |  |       |  |                       |  |  |  |
| Wm. C. March F.H., Inc.  |  |                                     |  | 1101 E. North Ave.   |  |                                    |  | SEP 11 1980   |  |                                      |  | [Signature]   |  |       |  |                       |  |  |  |



U.S. DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

OFFICE OF THE ASSISTANT ATTORNEY GENERAL  
WASHINGTON, D.C.

RECEIVED  
JAN 10 1962

TO THE ATTORNEY GENERAL  
FROM THE ASSISTANT ATTORNEY GENERAL

SUBJECT: [Illegible]

REFERENCE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                  |  |  |  |  |  |   |  | REG. NO. 22200                                       |                                   |
|--|--|------------------|--|--|--|--|--|---|--|--|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT)<br>Claude Anthony Kane Jr.  |  |                  |  |  |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH 9 DAY 28 YEAR 1980  |                                   |
| 2. SEX<br>male   |  | 4. RACE<br>black |  | 5. DATE OF BIRTH<br>MONTH 6 DAY 20 YEAR 80 |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. 3 DAYS 8   |  | IF UNDER 24 HRS.<br>MONTHS HOURS MIN.                 |  | 2b. DATE PRONOUNCED DEAD<br>MONTH 9 DAY 28 YEAR 1980 |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                                  |  |                                   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>26 Masthead Court |  |  |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br>MD   |  |                  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN<br>Baltimore   |  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                   |
| 14. FATHER'S NAME<br>Claude A. Kane Sr.  |  |                  | 15. MOTHER'S MAIDEN NAME<br>Julie McKay Kane   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>No   |  |   |  |  |                                   |
| 16b. SOCIAL SECURITY NO.<br>N/A  |  |                  | 17. INFORMANT ADDRESS<br>Claude A. Kane Sr. 26 Masthead Ct.  |  |  |  |  |   |  |  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>486 - IMMEDIATE CAUSE (a) <u>Interstitial pneumonitis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |                  |  |  |  |  |  |   |  |  |                                   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                  |  |  |  |  |  |   |  |  |                                   |
| 19a. DATE OF OPERATION   |  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |  |                                   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |                                   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET  |  | CITY OR TOWN  |  | COUNTY   | STATE                             |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                  |  |  |  |  |  |   |  |  |                                   |
| ACTUAL SIGNATURE<br><i>JR Guard</i>  |  |                  | TITLE (SPECIFY)<br>Assistant   |  |  | MEDICAL EXAMINER   |  |   | DATE SIGNED<br>9/29/80   |  |                                   |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Hormez R. Guard, M.D.   |  |                  | ADDRESS<br>111 Penn Street, Balto, MD 21201  |  |  |  |  |   |  |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                  | 23b. DATE<br>10/1/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Pk. |  |  | 23d. LOCATION<br>CITY OR TOWN<br>Baltimore Co. MD     |  |  |                                   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H   |  |                  | ADDRESS<br>1101 E. North Ave.  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 30 1980   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Patricia Hebrady</i> |  |  |                                   |

8 1 2 3 4 5 6 7 8 9 10 11 12

13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200

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901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000

1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041 1042 1043 1044 1045 1046 1047 1048 1049 1050 1051 1052 1053 1054 1055 1056 1057 1058 1059 1060 1061 1062 1063 1064 1065 1066 1067 1068 1069 1070 1071 1072 1073 1074 1075 1076 1077 1078 1079 1080 1081 1082 1083 1084 1085 1086 1087 1088 1089 1090 1091 1092 1093 1094 1095 1096 1097 1098 1099 1100

1101 1102 1103 1104 1105 1106 1107 1108 1109 1110 1111 1112 1113 1114 1115 1116 1117 1118 1119 1120 1121 1122 1123 1124 1125 1126 1127 1128 1129 1130 1131 1132 1133 1134 1135 1136 1137 1138 1139 1140 1141 1142 1143 1144 1145 1146 1147 1148 1149 1150 1151 1152 1153 1154 1155 1156 1157 1158 1159 1160 1161 1162 1163 1164 1165 1166 1167 1168 1169 1170 1171 1172 1173 1174 1175 1176 1177 1178 1179 1180 1181 1182 1183 1184 1185 1186 1187 1188 1189 1190 1191 1192 1193 1194 1195 1196 1197 1198 1199 1200

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1801 1802 1803 1804 1805 1806 1807 1808 1809 1810 1811 1812 1813 1814 1815 1816 1817 1818 1819 1820 1821 1822 1823 1824 1825 1826 1827 1828 1829 1830 1831 1832 1833 1834 1835 1836 1837 1838 1839 1840 1841 1842 1843 1844 1845 1846 1847 1848 1849 1850 1851 1852 1853 1854 1855 1856 1857 1858 1859 1860 1861 1862 1863 1864 1865 1866 1867 1868 1869 1870 1871 1872 1873 1874 1875 1876 1877 1878 1879 1880 1881 1882 1883 1884 1885 1886 1887 1888 1889 1890 1891 1892 1893 1894 1895 1896 1897 1898 1899 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advice.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH80 22201  
REG. NO.

|   |  |  |  |  |  |   |  |  |   |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|--|---|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SAMUEL</b>   |  |  | FIRST <b>KAPLAN</b>  |  |  | LAST  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>9-22-80</b>  |  |  |  | 2b. HOUR<br><b>4<sup>02</sup> A.M.</b>                 |   |  |
| 3. SEX<br><b>MAL</b>  |  |  | 4. RACE<br><b>CAUC</b>   |  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>8-07-01</b>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b>  |  |  |  | # UNDER 1 YEAR<br>MONTHS DAYS                          |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b>                                 |  |  |  | MD.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE COUNTY GEN. HOSPITAL</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PRINTER</b>  |  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PRINTING</b> |  |  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY<br><b>BALTO.</b>   |  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  | 13e. STREET ADDRESS<br><b>3510 LANGREHR RD. #21207</b> |   |  |
| 14. FATHER'S NAME<br>FIRST <b>JOSEPH</b> MIDDLE <b>M.</b> LAST <b>KAPLAN</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>LENA</b> MIDDLE <b>UNKNOWN</b>  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>214-26-9188A</b>   |  |  | 17. INFORMANT<br><b>MRS. FAYE KAPLAN</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  | 19a. DATE OF OPERATION<br><b>N/A</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |

|   |  |  |   |  |  |  |  |  |   |  |  |  |  |  |   |  |  |
|---|--|--|---|--|--|--|--|--|---|--|--|--|--|--|---|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |  |  |  |   |  |  |  |  |  |   |  |  |
| 21a. DATE OF OPERATION<br><b>N/A</b>  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b> |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-17-80</b> to <b>9-22-80</b> , that (I) (we) lost saw the deceased alive on <b>9-22-80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death. |  |  |   |  |  |  |  |  |   |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Wendy A. V. Reddy</b>  |  |  |   |  |  | 22c. DATE SIGNED<br><b>9-22-80</b>   |  |  |   |  |  |  |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Wendy A. V. Reddy</b>   |  |  |   |  |  | 22e. ADDRESS<br><b>BALTO. COUNTY GEN. HOSPITAL<br/>RANDALLSTOWN, MD 21123</b>  |  |  |   |  |  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>SEPT. 24, 1980</b>                                |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CHIZUK AMINO</b>                      |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                                   |  |  |  |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS<br><b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>  |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 26 1980</b>                            |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McCreedy</b>  |  |  |  |  |  |   |  |  |

1055-08

7/10/55

1055-08



1055-08

1055-08

1055-08

1055-08

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH-16 25M  
(VRA 15, 4) 1/79TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 2 0 2

REG. NO.

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>LILLIAN R. KEMP  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9/14/80  |  | 2b. HOUR<br>3:20 PM  |
| 3. SEX<br>F   | 4. RACE<br>W   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 6 1929   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>51 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA.  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |  |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GBMC--6701 N. CHARLES ST. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br>OFFICER                      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>EXCAVATING  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD 13b. COUNTY BALTO 13c. CITY OR TOWN RUTOM   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>1500 OLD ORCHARD LANE                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William R. Rinker   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Edith Worsley   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>228-28-5902   | 17. INFORMANT<br>ADDRESS<br>Charles T. Kemp 3rd Same  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ACUTE RESPIRATORY FAILURE<br>431-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) LARGE R. INTRACEREBRAL BLEED WITH<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) EXTENSIVE HEMORRHAGE INTO DILATED VENTRICLES<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>PEPTIC ULCER DISEASE   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/7/80 to 9/14/80, that (I) (we) lost saw the deceased alive on 9/14/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |
| 22b. SIGNATURE<br>Dean Mesologites  |  | DEGREE<br>MD   |   | 22c. DATE SIGNED<br>19 Sept. 1980  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dean Mesologites   |  | 22e. ADDRESS<br>GBMC   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  | 23b. DATE<br>9-17-80   | 23c. NAME OF CEMETERY OR CREMATORY<br>Shenwood Church  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO MD                         |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Crown Funeral Chapel  |  | ADDRESS<br>Crown Funeral Chapel  |   | 25a. DATE REC'D. BY REGISTRAR<br>SEP 19 1980                                   | 25b. REGISTRAR'S SIGNATURE<br>R. J. H. H. H.   |

MEDICAL CERTIFICATION

9/9

4905 BP



WILLIAM K KEMP 9/14/80 3:20P

BALTIMORE COUNTY

GENC--6701 N. CHARLES ST.

TOWSON

ACUTE RESPIRATORY FAILURE  
LARGE R. INTRACEREBRAL BLEED WITH  
EXTENSIVE HEMORRHAGE INTO  
DILATED VENTRICLES

PEPTIC ULCER DISEASE

9/14/80 08 9/17/80 08 9/17/80 08

SEP 19 1980

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 2 0 3

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |   |   |  |  |  |  |                  |  |  |
|--|--|--|---|---|--|--|--|--|------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Tillie KIELCZEWSKI  |  |  | 2b. DATE OF DEATH<br>MONTH DAY YEAR<br>9 3 80 |   |  | 2c. HOUR<br>P<br>5:00 M  |  |  |                  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 28 09   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |                  | 7c. IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |  |                  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph Hospital |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS<br>MD 13b. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> Baltimore 2427 Eastern AVE  |  |  |   |   |  |  |  |  |                  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN MIECZKOWSKI   |  |  |   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN   |  |  |                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |  |   | 16b. SOCIAL SECURITY NO.<br>217 03 4822A  |  | 17. INFORMANT<br>ADDRESS<br>JOHN KIELCZEWSKI 2427 EASTERN AVE  |  |  |                  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u><br>1519<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>gastic carcinoma with metastases to the liver</u><br>(c) <u>to the liver</u>                           |  |  |   |   |  |  |  |  |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  |  |  |   |   |  |  |  |  |                  |  |  |
| 19a. DATE OF OPERATION   |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |                  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <u>Aug. 29</u> , 19 <u>80</u> , to <u>Sept. 3</u> , 19 <u>80</u> , that <u>X</u> (we) last saw the deceased alive on <u>Sept. 3</u> , 19 <u>80</u> , and that in <u>X</u> (our) opinion death occurred on the date and hour and from the causes stated above; <u>X</u> (we) (did) <u>(X) (not)</u> view the body after death. |  |  |   |   |  |  |  |  |                  |  |  |
| 22b. SIGNATURE<br><u>Adel S. EL-Hennawy</u>  |  |  |   |   |  | DEGREE <u>M.D.</u><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>ADEL S. EL-HENNAWY</u>   |  |  |   |   |  | 22e. ADDRESS<br><u>7620 York Rd. 21204</u>   |  |  |                  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(LABEL)<br><u>BURIAL</u>  |  |  |   | 23b. DATE<br><u>9/8/80</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Holy Rosary Cem</u>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore MD</u>                    |                  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Raymond L. Kaczorowski</u>  |  |  |   |   |  | ADDRESS<br><u>2525 Fleet St.</u>   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>SEP 4 1980</u>                                   |                  | 25b. REGISTRAR'S SIGNATURE<br><u>Harry McCreedy</u>  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

00:00

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

|   |  |  |  |   |  |   |  |  |  |       |  |
|---|--|--|--|---|--|---|--|--|--|-------|--|
| 1. FOR STATE REGISTRAR  |  | XC 633034  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | 8 0 2 2 2 0 4   |  | REG. NO.   |  |       |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>'STEPHEN WILLIAM KING</b>   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>SEPTEMBER 25, 1980</b>                                   |  | 2b. HOUR<br><b>11:55 AM</b>  |  |       |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>MARCH 1 1 895</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>85</b>   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                             |  |  |  |       |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VA MEDICAL CENTER, FORT HOWARD, MD</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |       |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1805 POPULAR GROVE STREET</b>  |  |       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>WILLIE KING</b>   |  | 15. MOTHER'S MAIDEN NAME MIDDLE LAST<br><b>ELIZABETH SMITH</b>   |  |   |  |   |  |  |  |       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/>   |  | 16b. SOCIAL SECURITY NO.<br><b>WW1 217 07 3098</b>   |  | 17. INFORMANT ADDRESS<br><b>CLINICAL RECORDS, VAMC, FORT HOWARD, MD</b>   |  |   |  |  |  |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b>  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MONTHS</b>  |  |       |  |
| 4592<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |   |  |   |  | DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC BRAIN SYNDROME</b>   |  | YEARS |  |
|   |  |  |  |   |  |   |  | DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</b>   |  | YEARS |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>CARCINOMA OF RIGHT LUNG; GANGRENE ON RIGHT FOOT</b>   |  |  |  |   |  |   |  |  |  |       |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |       |  |
| 22a. I certify that (this hospital) attended the deceased from <b>NOVEMBER 5, 1979</b> to <b>SEPTEMBER 25, 1980</b> , that (I) (we) lost<br>saw the deceased alive on <b>SEPTEMBER 25, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |       |  |
| 22b. SIGNATURE<br><b>Wm Shyang Wu</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED   |  |       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WEN SHYANG WU M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>VA MEDICAL CENTER, FORT HOWARD, MD 21052</b>   |  |   |  |  |  |       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>9/29/1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto Nat. Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |  |  |  |       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William C. March F/H 1101 East North Ave.</b>  |  |  |  | 25. DATE REC'D. BY REGISTRAR<br><b>SEP 29 1980</b>  |  |   |  |  |  |       |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 2 0 5

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |   |  |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Myrtle H. Kinsey</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>9-2-80</b> |   |  | 2b. HOUR<br><b>220 P.M.</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>caucasian</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>4 4 1891</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><b>89</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PICKERS GILL</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Balto</b>   |   | 13c. CITY OR TOWN<br><b>Balto</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Clinton A Kinsey</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Bertha E Hax</b>   |   | 13e. STREET ADDRESS<br><b>3215 N Charles St</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>un known</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-46-0036</b>  |   | 17. INFORMANT ADDRESS<br><b>Jacqueline De Paupe R.N.</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>4029<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure</b> 9-7-80<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Hypertensive Endocardial Disease</b> 1974-80<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <b>9/2/80</b> |  |   |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1979</b> , 19____, to <b>9-2-80</b> , that (I) (we) last saw the deceased alive on <b>9-1-80</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>J. Bradshaw Higgins MD</b>   |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>    |  | 22c. DATE SIGNED<br><b>9-3-80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. Bradshaw Higgins</b>   |  | 22e. ADDRESS<br><b>2743 Madison Ave</b>   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>   |  | 23b. DATE<br><b>9/2/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Anatomy Board</b>   |  |   |   | ADDRESS<br><b>Balto., Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 9 1980</b>  |  |
|   |  |   |   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony M. Brady</b>   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

Dear Mr. [illegible]

I have your letter of [illegible]

and am sorry to hear that [illegible]

you are having trouble with [illegible]

the [illegible] [illegible]

and I am sure that [illegible]

you will be able to [illegible]

and I am sure that [illegible]

you will be able to [illegible]

and I am sure that [illegible]

you will be able to [illegible]

and I am sure that [illegible]

you will be able to [illegible]

and I am sure that [illegible]

you will be able to [illegible]

and I am sure that [illegible]

you will be able to [illegible]

and I am sure that [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 38 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 80 22206   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>DONALD HARVEY KIRK, Sr.</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 21 80</b>   |  | 2b. HOUR<br><b>8:45 P</b>   |  | 3. SEX<br><b>MALE</b>  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 14, 1917</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. COUNTY</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BECH. Old Court Rd. Balto. 21133</b>  |  | 12a. USUAL OCCUPATION<br>(If Executive or Professional)<br><b>Electric Co.</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>ELECTRIC CO.</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Howard</b>  |  | 13c. CITY OR TOWN<br><b>Ellicott City</b>   |  | 13d. STREET ADDRESS<br><b>3430 FONT HILL 21043</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Stanley Arthur Kirk</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Susan Iola Nichols</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217-09-7610</b>  |  |
| 17. INFORMANT<br><b>Ellicott City, Md. 21043</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Carcinomatous primary unknown</b><br>1539<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Primary colon carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  | 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. DATE OF OPERATION<br><b>9/21/80</b>   |  | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  | 21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21d. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21d. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>9/14</b> 19 <b>80</b> to <b>9/21</b> 19 <b>80</b> , that (I) (we) saw the deceased alive on <b>9/14</b> 19 <b>80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><b>E. Gorbaty MD</b>  |  | 22c. DATE SIGNED<br><b>9/21/80</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Elliott Gorbaty</b>  |  |
| 22b. SIGNATURE<br><b>E. Gorbaty MD</b>   |  | 22c. DATE SIGNED<br><b>9/21/80</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Elliott Gorbaty</b>   |  | 22e. ADDRESS<br><b>Baltimore County Hospital</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>9/25/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Mausoleum</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>1630 Edmondson Ave. Catonsville, Md.</b>  |  | 25. DATE REC'D. BY REGISTRAR<br><b>SEP 25 1980</b>  |  | 26. REGISTRAR'S SIGNATURE<br><b>Patricia Kelly</b>  |  | 27. REGISTRAR'S SIGNATURE<br><b>Patricia Kelly</b>   |  |

0001 2 5 332 2812 . . . 0014 0013 0012 0011 0010 0009 0008 0007 0006 0005 0004 0003 0002 0001

2nd May

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 0 2 2 2 0 7<br>REG. NO.   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |  | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>WILLIAM KLAUNBERG  |  |   |  | September 22, 1980  |  |  |  | 6:10a M  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>3-16-95  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                          |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>ROSSVILLE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>FRANKLIN SQUARE HOSPITAL |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SALES               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>DAIRY   |  |
| 13a. STATE<br>MARYLAND   |  |   |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>ROSEDALE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>JOHN KLAUNBERG  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>CAROLINE  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>212108627A  |  | 17. INFORMANT ADDRESS<br>DORIS MANNER 8001 NEIGHBORS AVENUE   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4280 Cardio-respiratory Failure: Congestive</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Heart Failure</u><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                    |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                 |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August 2</u> , 19 <u>80</u> , to <u>September 22</u> , 19 <u>80</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>September 22</u> , 19 <u>80</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death. |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>R. I. Rothbaum</u>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  |  |  | 22c. DATE SIGNED<br>9/22/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R. I. Rothbaum  |  |   |  | 22e. ADDRESS<br>9000 Franklin Square Drive 21237  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>9-25-80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                        |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Philip F. Czech   |  |   |  | ADDRESS<br>1211 Chesaca Ave.  |  | 25a. DATE<br>SEP 23 1980   |  |  |  |
|  |  |   |  |   |  | REGISTRAR'S SIGNATURE  |  |  |  |

80 55 08



George F. (see 1st column)  
P-122 (see 1st column)  
P-122 (see 1st column)

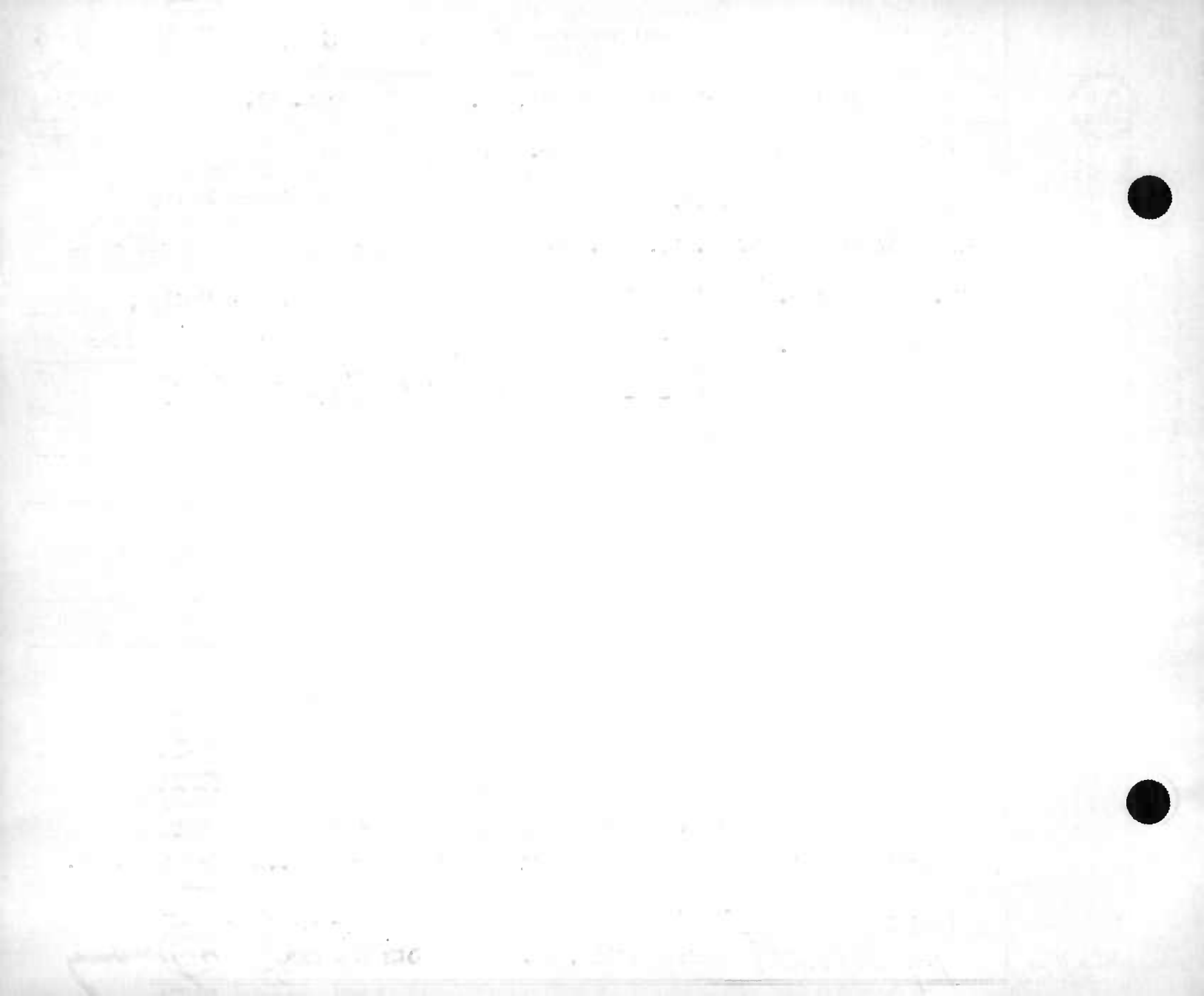


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 0 2 2 2 0 8   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>William Albert Kline, Sr.  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>Sept. 23, 1980 |   |  | 2b. HOUR<br>12:36a M   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Feb. 20, 1913  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Balto. Co. Gen. Hospital     |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Salesman   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Ice Cream   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Md. Balto. Owings Mills   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br>37 E Tahoe Circle   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Frank H. Kline   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE<br>Mary Katherine Schaeffer   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>215-09-4055   |  | 17. INFORMANT ADDRESS<br>Lorraine Kline 37 E Tahoe Circle<br>Owings Mills, Md.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial infarction</u><br>410 -<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) <u>arteriosclerosis</u><br>(c) <u>DUE TO, OR AS A CONSEQUENCE OF</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| MEDICAL CERTIFICATION   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Milton Schlenoff  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Milton Schlenoff   |  | 22e. ADDRESS<br>11969 Reisterstown Rd., Reisterstown, Md.   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Sept. 25, 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Western Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland   |  |
| 24. FUNERAL DIRECTOR NAME<br>H.G. Edhardt   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 25 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>notary McBrady   |  |
| ADDRESS<br>Owings Mills, Md.  |  |   |  |   |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. IF YOU ARE THE FUNERAL DIRECTOR, PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 22209

FOR  
1- STATE  
REGISTRAR

|  |                         |  |  |   |  |   |  |   |  |
|--|-------------------------|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DORIS Wilder Knickerbocker</b>  |                         |  | 2a. DATE KNOWN OF DEATH<br>MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 19 <b>94</b> 19 <b>80</b> |   |  | 2b. HOUR <b>3:04</b> AM   |  |   |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>24</b> YEAR <b>98</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.  | IF UNDER 1 YR.<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>   | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD<br>MONTH <b>9</b> DAY <b>4</b> YEAR <b>1980</b>                        |  |   | 2d. HOUR <b>3:09</b> AM                                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MASS. USA</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Co.</b>                                    |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Ronville Md</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5435 Princess Drive</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Homemaking</b>                              |  |
| 13a. STATE<br><b>Delaware</b>  |                         | 13b. COUNTY<br><b>Sussex</b>   |  | 13c. CITY OR TOWN<br><b>Del Mar</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>Box 69, R.D. 1</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>DAVID</b> MIDDLE <b>A.</b> LAST <b>Wilder</b>  |                         |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b>Simes</b> LAST <b>Simes</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No.</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>062529158</b>   |  | 17. INFORMANT<br><b>Elaine K. Beaver</b>  |  |   |  | ADDRESS<br><b>5435 Princess Dr. 21237</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Atherosclerotic Cardiovascular Disease</b><br><b>429.2</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |  |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Undet</b> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Diabetes mellitus - Chronic Bilateral Saphenous phlebitis</b>  |                         |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>X</b>   |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH   |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)    |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>John C. Hyle</b>  |                         |  | TITLE (SPECIFY)<br><b>Dpt</b>  |   |  | MEDICAL EXAMINER  |  | DATE SIGNED<br><b>9-4-80</b>  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>JOHN C. Hyle</b>   |                         |  | ADDRESS<br><b>7527 Belair Rd Baltimore Md 21236</b>  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>9/8/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Kensico Cemetery</b>   |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Valhalla N.Y.</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lassahn Funeral Home</b>  |                         |  |  | ADDRESS<br><b>7401 Belair Rd.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 8 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                    |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 0 2 2 2 1 0  
REG. NO.1. FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |  |   |  |  |  |
|--|--|--|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ingraham Meade KNIGHT   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>September 7, 1980               |   |  | 2b. HOUR<br>? M  |   |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 29, 1907   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Cockeysville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Redmare Ct. Apt. 3D |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Broker           |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Real Estate   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  | 13b. COUNTY<br>Balto.  |   | 13c. CITY OR TOWN<br>Cockeysville                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>Redmare Ct. Apt. 3D |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank P. Knight  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mable Lyman           |   |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  | 16b. SOCIAL SECURITY NO.<br>705 05 0084                                |   | 17. INFORMANT<br>ADDRESS<br>Dr. J. Franklin Knight, Monkton, Md. |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>A-S Cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>5 yf</u><br>Approximate interval between onset and death: <u>10 min</u> |  |  |  |   |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 7, 1970</u> to <u>9/7, 1980</u> , that (I) (we) last saw the deceased alive on <u>8/20, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                                   |  |  |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Norman R. Freeman</u> MD<br>22b. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |   |  | 22c. DATE SIGNED<br>9/9/80   |   | 22d. ADDRESS<br>11 W. 29th St., Balto., Md.  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>9/11/80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Govans Presbyterian        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md.                                       |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>ADDRESS<br>4905 York Road Balto., Md. 21212   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>SEP 9 1980                      |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert M. Brady</u>  |  |  |  |



Frank

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to the  
Knight

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705 05 0084 Dr. J. Franklin Kn...

705 05 0084 Dr. J. Franklin Knight, Monk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |                       | 8 0 2 2 2 1 1  |  |
|---|--|--|--|---|--|--|--|---|-----------------------|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |  |  |   |                       | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Anna C Koenig   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>September 1, 1980                          |  |   | 2b. HOUR<br>8:45 P.M. |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>June 9, 1889   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>91 YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |                       | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                   |  |   |                       |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Armcast Nursing Home |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                      |                       | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland  |  |  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Parkville   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                       | 13e. STREET ADDRESS<br>3319 Putty Hill Ave   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Henry HXX Hemelt   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Elizabeth Fleishmann  |  |  |  |   |                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  |  |  | 16b. SOCIAL SECURITY NO.<br>217-14-2813D  |  | 17. INFORMANT ADDRESS<br>Mrs Ruth Becker Same                                  |  |   |                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br>4039<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Cerebrovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |   |                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hr<br>20 yr  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Cerebral Hemorrhage into subarachnoid space</u>  |  |  |  |   |  |  |  |   |                       |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |                       |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |                       |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 18, 1960</u> to <u>Sept 1, 1980</u> , that (I) (we) lost saw the deceased alive on <u>Aug 26, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |   |                       |  |  |
| 22b. SIGNATURE<br><u>Frederick Vollmer</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>9-4-80  |                       |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Frederick Vollmer M.D.   |  |  |  | 22e. ADDRESS<br>6100 York Rd Baltimore, Maryland  |  |  |  |   |                       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>9/5/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens Of Faith  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                                  |                       |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Leonard J Ruck Inc.  |  |  |  | ADDRESS<br>Baltimore, Maryland  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 4 1980   |                       | 25b. REGISTRAR'S SIGNATURE<br><u>Jeffrey H. Brady</u>  |  |





REG. NO.

6010 REISTERSTOWN DR BALTO MD 21212

**NOT TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENAL ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. THE MEDICAL EXAMINER ALONE, WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR RECORDS. AFTER DEATH, WITHIN 72 HOURS, PAGE 3 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. AFTER DEATH, WITHIN 72 HOURS, PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 80 22213  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR XC 107 767<br>STATE REGISTRAR   |  |  |  |  |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM GEORGE KORB, SENIOR</b>  |  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPTEMBER 3, 1980</b>   |  | 2b HOUR<br><b>3:20 A.M.</b>  |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>WHITE</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>OCTOBER 7, 1897</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.   |  |
| 10 CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>V.A. MEDICAL CENTER</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>ROOFING</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE <b>MARYLAND</b> 13b COUNTY <b>Balto.</b> 13c CITY OR TOWN <b>Kingsville</b>   |  |  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e STREET ADDRESS<br><b>6607 Mt. Vista Road</b>   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES L. KORB</b>  |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MAMIE CONSER</b>  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b>   |  | 16b SOCIAL SECURITY NO.<br><b>WWI</b>  |  | 17 INFORMANT ADDRESS<br><b>George P. Korb Same</b>   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b><br><b>4148</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>HYPERTENSIVE ARTERIOSCLEROTIC</b><br>(b) <b>CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>POSSIBLE CARCINOMA OF LUNG (LEFT UPPER LUNG)</b> |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>OVER 10 YEARS</b><br><b>OVER 10 YEARS</b><br><b>YEARS</b>               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>HISTORY OF ACUTE MYOCARDIAL INFARCTION; HISTORY OF CONGESTIVE HEART FAILURES</b>  |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>MARCH 12, 1980</b> to <b>SEPTEMBER 3, 1980</b> , that (I) (we) lost saw the deceased alive on <b>SEPTEMBER 3, 1980</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |
| 22b SIGNATURE <b>Wen Shyang Wu</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c DATE SIGNED<br><b>9/3/80</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WEN-SHYANG WU, M.D.</b>   |  |  |  | 22e ADDRESS<br><b>V.A.M.C., FORT HOWARD, MD 21052</b>  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremate</b>  |  | 23b DATE<br><b>Sept. 5, 1980</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>   |  |
| 24 FUNERAL DIRECTOR<br>NAME <b>Inc.</b> ADDRESS<br><b>LEONARD RUCK, 5305 HARFORD RD, BALTO., MD</b>  |  |  |  | 25a DATE REC'D. BY REGISTRAR<br><b>SEP 4 1980</b>  |  | 25b REGISTERED SIGNATURE<br><i>[Signature]</i>   |  |

8 0 5 5 1 8

SEP 4 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 0 2 2 2 1 4<br>REG. NO.   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Frederick John Kraus</i>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>9-6-80</i>   |  |   |  | 2b. HOUR<br><i>9 A. M.</i>   |  |
| 3. SEX<br><i>Male</i>  |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>3-9-1928</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>52</i> YRS.                                 |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Balto. Md.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto.</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>1709 White Oak Avenue - 21284</i> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Installer</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Western Electric</i>                                 |  |
| 13a. STATE<br><i>Md.</i>   |  |  |  | 13b. COUNTY<br><i>Balto.</i>  |  | 13c. CITY OR TOWN<br><i>Balto</i>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Frederick J. Kraus</i>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Mary Murphy</i>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>Yes</i>  |  | 16b. SOCIAL SECURITY NO<br><i>1946-1948 214-24-0163</i>  |  | 17. INFORMANT ADDRESS<br><i>Mrs. Rita N. Kraus - 1709 White Oak Ave. - 21284</i>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i><br><i>4592</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <i>Arteriosclerotic Cardiovascular disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>5 + yrs.</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>5 min</i> |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>(I DID NOT TREAT HIM)</i> , 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Samuel O'Mansky</i>   |  |  |  | DEGREE<br><i>MD</i>   |  |   |  | 22c. DATE SIGNED<br><i>Sept 8 '80</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>SAMUEL O'MANSKY</i>  |  |  |  | 22e. ADDRESS<br><i>1405A LOCH RAVEN BLVD.</i>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>9-9-80</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Dulaney Valley Cem.</i>  |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Cockeysville Md.</i>                           |  |
| 24. FUNERAL DIRECTOR NAME<br><i>John C. Miller Inc</i>   |  |  |  | ADDRESS<br><i>6415 Belair Rd. - 21206</i>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>SEP 15 1980</i>  |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony McCready</i>   |  |   |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |  |  |   |  |   |  | REG. NO. 80 22215   |  |   |  |                           |  |
|--|--|-------------------------|--|--|--|---|--|---|--|---|--|---|--|---------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ISAAC KRELL</b>   |  |                         |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH ESTIMATED<br><b>September 1, 1980</b>                       |  | 2b. HOUR<br><b>7 P M</b>  |  |                           |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b> |  | 5. DATE OF BIRTH<br><b>MAY 29, 1938</b>  |  | 6. AGE (IN YEARS)<br><b>47 YRS.</b>                               |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN   |  | 2c. DATE OF DEATH<br><b>September 1, 1980</b>                           |  | 2d. HOUR<br><b>10 P M</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>POLAND</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.     |  |                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2723 WOODCOURT RD.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>OWNER</b>   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SUPER MARKET</b>                |  |                           |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |                         |  | 13b. COUNTY<br><b>BALTO.</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>2723 WOODCOURT RD. #21209</b>                             |  |   |  |                           |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>HARRY KRELL</b>  |  |                         |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>CHAVA VURKOW</b> |  |   |  |   |  |   |  |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>NO</b>  |  |                         |  | 16b. SOCIAL SECURITY NO.   |  |   |  | 17. INFORMANT<br><b>MRS. AVIVA KRELL</b><br><b>2723 WOODCOURT RD. BALTO., MD 21209</b>  |  |   |  |   |  |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>410 - Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b>       |  |                         |  |  |  |   |  |   |  |   |  |   |  |                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                         |  |  |  |   |  |   |  |   |  |   |  |                           |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |                           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |   |  |                           |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |                           |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |  |  |   |  |   |  |   |  |   |  |                           |  |
| ACTUAL SIGNATURE<br><b>Charles O'Donnell</b>   |  |                         |  | MEDICAL EXAMINER<br><b>Charles O'Donnell, Deputy</b>   |  |   |  |   |  | DATE SIGNED<br><b>9/1/80</b>  |  |   |  |                           |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>CHARLES O'DONNELL, M.D.</b>  |  |                         |  | ADDRESS<br><b>7561 YORK RD. TOWSON, MD.</b>  |  |   |  |   |  |   |  |   |  |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |                         |  | 23b. DATE<br><b>SEPT. 2, 1980</b>  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH TFILOH</b>  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b> |  |                           |  |
| 24. FUNERAL DIRECTOR NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>   |  |                         |  | 24b. ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 3 1980</b>  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Kathy Brady</b>                        |  |                           |  |

BP

DHMH - 17  
1/VR A15 ME (51)  
15M 7/76



80 222

17  
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19

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21

22  
23



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 2 1 6

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |  |  |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Bryson W. Krout</b>                        |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>September 26, 1980</b> |   |  | 2b. HOUR<br><b>M</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 3 1914</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cockeysville</b>                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>124 Warren Road - Cockeysville</b>  |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Balto. County</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bur./Highways</b>                         |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Balto.</b> 13c. CITY OR TOWN <b>Cockeysville</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>124 Warren Road, Cockeysville</b> |   |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Howard C. Krout</b>                  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Amelia Hess</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>---</b>   |   | 17. INFORMANT ADDRESS<br><b>Mrs. Elizabeth L. Krout, 124 Warren Rd.</b>   |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**410-**

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 23<sup>rd</sup></u> 19 <u>77</u> , to <u>Sept 26<sup>th</sup></u> 19 <u>80</u> , that (I) <u>lost</u> saw the deceased alive on <u>July 31<sup>st</sup></u> 19 <u>79</u> , and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Kevin Quinn</i>  |  | DEGREE<br><i>MD</i>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>10/3/80</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kevin Quinn, M. D.</b>  |  | 22e. ADDRESS<br><b>1205 York Rd., Baltimore, Md. 21204</b>             |  |  |  |   |  |

|   |  |                             |  |  |  |  |  |
|---|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                         |  | 23b. DATE<br><b>9/30/80</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville, Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>J. E. Lowell Lemmon, 10 W. Padonia Rd.</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 6 1980</b>               |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert M. Brady</i>                   |  |

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1. The first part of the report is a general description of the project and its objectives. It is followed by a detailed description of the methods used in the study. The results of the study are then presented in a series of tables and figures. The final part of the report is a discussion of the results and their implications for future research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a description of the experimental design, the subjects used, and the procedures used to collect and analyze the data. This part is followed by a description of the results of the study, which are presented in a series of tables and figures.

3. The third part of the report is a discussion of the results and their implications for future research. It includes a summary of the findings, a discussion of the strengths and limitations of the study, and suggestions for future research. The final part of the report is a conclusion, which summarizes the main findings of the study and their implications for future research.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR  |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR  |  | 2b. HOUR   |  |
| FRANK J. KRUG   |  |  |  | 9-20-80   |  | 6:15 PM   |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. UNDER 1 YEAR  |  |
| M   |  | W  |  | 11 17 05  |  | 74 YRS.   |  | MONTHS DAYS HOURS MIN  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 9. CITIZEN OF WHAT COUNTRY?  |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH                               |  | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |
| MD.   |  | U.S.A.   |  |   |  | BALTO. COUNTY MD.   |  | DELIVERY DRIVER  |  |
| 13. CITY OR TOWN OF DEATH   |  | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     |  | 15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 16. KIND OF BUSINESS OR INDUSTRY                                    |  |  |  |
| Randallstown  |  | Balto Co. GEN HOSP   |  | Delivery Driver   |  | Florist   |  |  |  |
| 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 18. INSIDE CITY LIMITS?  |  | 19. STREET ADDRESS  |  |   |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  |   |  |  |  |
| MD.   |  | BALTO  |  | Pikesville  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 4214 Mifford Mill Rd.  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |  |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  |   |  |   |  |  |  |
| JACOB G. KRUG   |  | ANNA HUBKA   |  |   |  |   |  |  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 17. SOCIAL SECURITY NO.  |  | 18. INFORMANT   |  | ADDRESS   |  |  |  |
| NO  |  | 213-10-2327  |  | ANNA Fowler   |  | 21221 84 Berkshire Rd.  |  |  |  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):)   |  |  |  |   |  |   |  |  |  |
| PART 1: DEATH WAS CAUSED BY:  |  |  |  |   |  |   |  |  |  |
| IMMEDIATE CAUSE (a): Cardio-pulmonary arrest  |  |  |  |   |  |   |  |  |  |
| 5715 DUE TO, OR AS A CONSEQUENCE OF (b): Hepatic failure  |  |  |  |   |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c): cirrhosis of the liver  |  |  |  |   |  |   |  |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): chronic obstructive lung disease   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
|   |  | P.M. 19  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
|   |  |  |  |   |  |   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 17, 19 80, to Sept. 20, 19 80, that (I) (we) lost saw the deceased alive on Sept. 20, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED  |  |   |  |  |  |
| Shassem Pourmotarred, M.D.  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 9-20-80   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |   |  |   |  |  |  |
| GHASSEM POURMOTARRED  |  | Balto. County Gen. Hospital  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (IF SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |  |  |
| CREMATION   |  | 9-22-80  |  | Westview Cem  |  | BALTO MD  |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| MATTHEWS  |  | 3021 EASTERN AVE   |  | SEP 26 1980   |  | L. J. M. M. M.  |  |  |  |

1880



*[Faint, illegible handwriting covering the main body of the page, possibly representing a list or ledger entries.]*

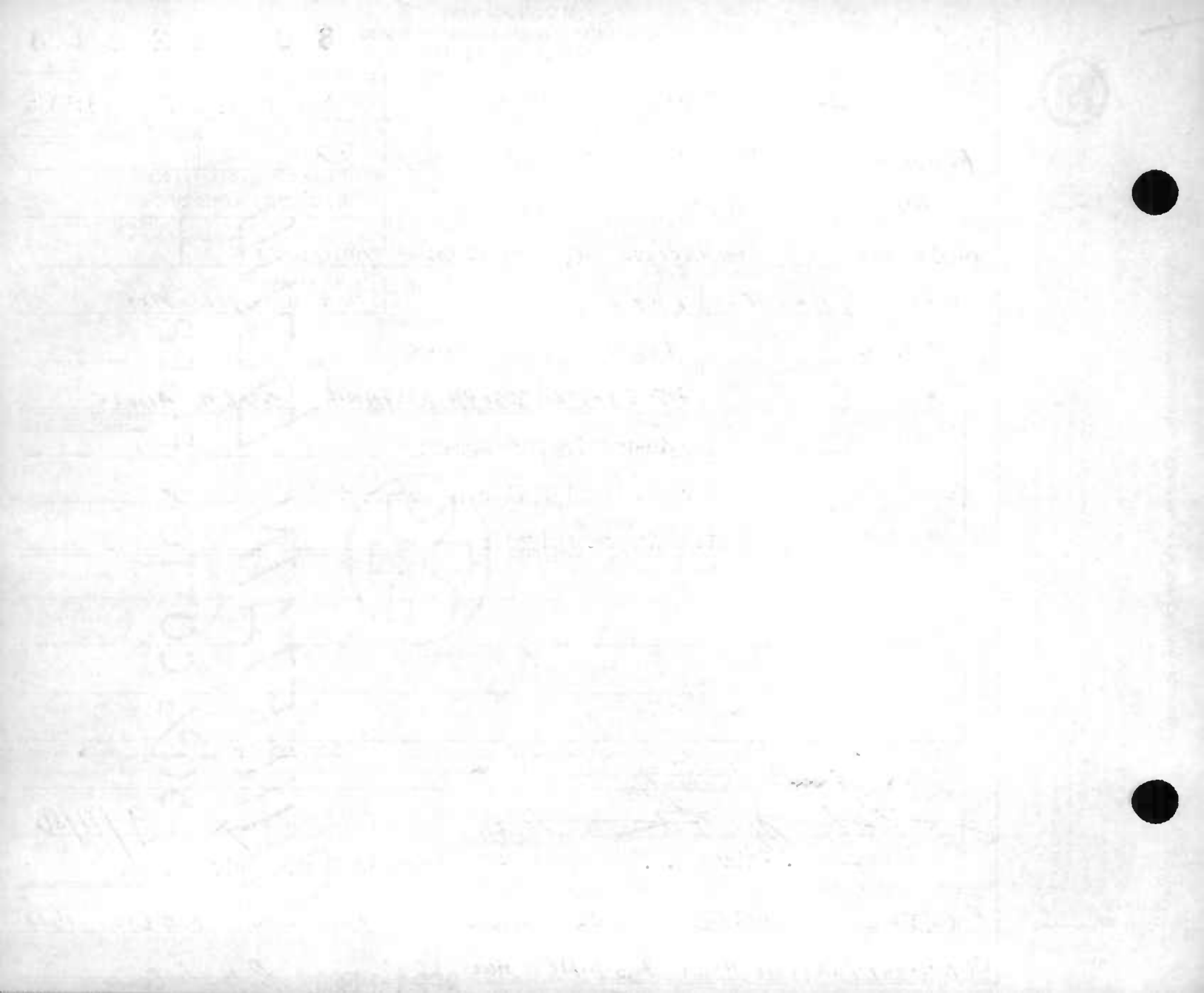
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  | 8 0 2 2 2 1 8                                |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |  |  |   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH  |  |  |  |   |  | MONTH DAY YEAR   |  | 2b. HOUR                                     |  |
| Anna Mary KUYAWA  |  | September 11, 1980   |  |  |  |   |  |  |  | 1:50 a.m.                                    |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.                             |  |
| FEMALE  |  | WHITE  |  | OCTOBER 20 1887  |  | 92 YRS.   |  | MONTHS DAYS  |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |
| MD  |  | USA  |  |  |  | Baltimore County MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| ROSEVILLE   |  | FRANKLYN SQ. HOSPITAL  |  |  |  |   |  | HORSEWIFE  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |  |  |
| MD  |  | BALTO.   |  | ESSEX  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 404 FRANKLIN AVE   |  |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |  |  |  |  |
| JOSEPH  |  | FEHN   |  | WINK   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |  |  |  |  |  |
| NO  |  | 215-54-0868  |  | JOSEPH KUYAWA SAME AS ABOVE  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Cardio-respiratory Arrest   |  |  |  |  |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |  |  |  |
| (b) Chronic Renal Failure, Bacteremia   |  |  |  |  |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |  |  |  |
| (c) Diabetic Ketoacidosis   |  |  |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
|   |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED   |  | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |  |  |  |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  |   |  |  |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET   |  | CITY OR TOWN  |  | COUNTY   |  | STATE  |  |
| 22a. I certify that (this hospital) attended the deceased from September 3, 19 80, to September 11, 19 80, that (we) last saw the deceased alive on September 11, 19 80, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (and) (we) view the body after death. |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED   |  |   |  |  |  |  |  |
| Hattie M. Faison M.D.   |  | M.D.   |  | 9/11/80  |  |   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |  |  |  |  |
|   |  | 9000 Franklin Square Drive 21237   |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |  |  |  |  |
| BURIAL  |  | 9/13/80  |  | OAK LAWN   |  | EASTWOOD  |  | BALTO  |  | MD   |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |  |  |  |
| CONNELLY FUNERAL HOME   |  | 300 MACE AVE   |  | SEP 15 1980  |  |   |  |  |  |  |  |



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR<br>STATE<br>REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 0 2 2 2 1 9<br>REG. NO.   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>EILEEN O. LACK  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9-15-80 |   |  | 2b. HOUR<br>4:14 PM   |  |
| 3. SEX<br>F  |  | 4. RACE<br>CAUC   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 4 21   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. County MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Balto. County Gen. Hosp. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Md.  |  |   |  | 13b. COUNTY<br>Catonsville  |  | 13c. STREET ADDRESS<br>108 Glenrae Drive  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Eugene O'Malley  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rita Schmidt   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-07-7949  |  | 17. INFORMANT ADDRESS   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 410- ACUTE MYOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>N/A  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-5-80 to 9-15-80, that (I) (we) last saw the deceased alive on 9-15-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (did not) view the body after death.   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>VUNDYACA K. REDDY  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>9-15-80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>VUNDYACA K. REDDY   |  |   |  | 22e. ADDRESS<br>BALTIMORE COUNTY GEN HOSPITAL<br>RANDALLSTOWN, MARYLAND   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal  |  | 23b. DATE<br>9/15/80  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Anatomy Board  |  |   |  | ADDRESS<br>Balto., Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 19 1980  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |   |  |





Mr.

USA

Radio. County

Washington

Radio. County No. 100

San Jose

Mr.

San Jose

Glenn Drive

Engine

Radio

Radio

Schmidt

100-07-100

No.

SEP 19 1980

Radio. No.

Radio. No.

100-07-100

Radio



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at \_\_\_\_\_

| FOR<br>STATE<br>REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   | 8 0 2 2 2 2 0   |  | REG. NO.   |   |  |
|--|--|--|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Margaret Elizabeth Lancaster  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Sept. 3, 1980          |   |  | 2b. HOUR<br>5 pm   |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 17, 1907   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Forest Haven Nursing Home |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Factory   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Maryland   |  |  | 13c. COUNTY<br>Baltimore                                      |   | 13d. CITY OR TOWN<br>Dundalk                       |  | 13e. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James A. Lancaster   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Etta Sargent |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |  | 16b. SOCIAL SECURITY NO.<br>211-20-8616                       |   | 17. INFORMANT<br>Dorothy Johnson (same as line 13) |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Stroke Sepsis</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Ascid-severe</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Stroke</u>   |  |  |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Dehydration Urine Infect</u>   |  |  |   |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 6, 1980</u> to <u>9-3</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>9-2</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |  |   |  |
| 23a. SIGNATURE<br><u>Harold Bob, MD.</u>   |  |  |   | DEGREE<br><u>MD</u>   |  | 22c. DATE SIGNED<br><u>9-4-80</u>  |   |  |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   | 22d. ADDRESS<br><u>7220 Park Heights 21208</u>  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Sept. 6, 80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill Memorial   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Duda-Ruck Funeral Home of Dundalk, Inc.  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>SEP 5 1980   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Patricia Halburdy</u>   |   |  |



*[Faint, illegible handwritten text covering the majority of the page, possibly a list or report.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 8022221  |  |  |  | REG. NO.   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR MIN   |  |
| Natalie   |  | L.   |  | LAUBACH  |  | September 3 1980   |  | 11:30   |  | P. M.  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  | 8. IF UNDER 24 HRS. HOURS MIN                        |  |
| Female  |  | White  |  | Jan. 15 1891   |  | 89   |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| Penna.  |  | U.S.A.   |  |  |  | Baltimore County MD  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| Randallstown  |  | Chapel Hill N. H.  |  |  |  | Decorator  |  | Interiors   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS   |  |  |  |
| Md.   |  | BALTO.   |  | Balto.   |  | YES  |  | Roland Ave.   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  |  |  |
| Charles   |  | Louise T. Dungan   |  | No   |  | 115-03-6391  |  | Ruth Laubach Pikesville, Md.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest  |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes |  |
| 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic C.V. Disease  |  |  |  |  |  |  |  |   |  | years  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-1-1974, to 9-2-80, 19, that (I) (we) last saw the deceased alive on 9-2-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED 9-4-80   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |  |  |   |  |  |  |
| Martin Strobel M.D.   |  | 59 Hanover Rd., Reisterstown, Md.  |  |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| Burial  |  | 9-5-80   |  | West Laurel Hill   |  | Bala Cynwyd Pa.  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  | ADDRESS  |  | 25. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |  |
| H. W. Jenkins & Sons Co. Balto., Md.  |  | 4905 York Rd.  |  | SEP 4 1980   |  |  |  |   |  |  |  |

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#1,14,15,17,FilmG547 9/25/80 kam

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 22222

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <u>Katherine</u> MIDDLE <u>ANNA</u> LAST <u>LAUENSTEIN</u>  |  | 2a. DATE OF DEATH<br>MONTH <u>9</u> DAY <u>9</u> YEAR <u>1980</u>   |  | 2b. HOUR<br><u>6:05</u> M   |  |
| 3. SEX<br><u>FEMALE</u>  |  | 4. RACE<br><u>WHITE</u>   |  | 5. DATE OF BIRTH<br>MONTH <u>7</u> DAY <u>28</u> YEAR <u>1890</u>                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>BALTO MD</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  | 8. AGE (IN YEARS LAST BIRTHDAY)<br><u>80</u> YRS.                                 |  |
| 10. CITY OR TOWN OF DEATH<br><u>BALTO CO</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Multi-Med. Cntr. &amp; Nursing Home</u> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>None</u>   |  |
| 13a. STATE<br><u>MD</u>  |  | 13b. COUNTY<br><u>BALTO.</u>  |  | 13c. CITY OR TOWN<br><u>ESSEX</u>   |  |
| 14. FATHER'S NAME<br>FIRST <u>JOHN</u> MIDDLE <u>FREUDENBURG</u> LAST <u>FREUDENBERG</u>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>Catherine</u> MIDDLE <u>LINK</u> LAST <u>Marie Frey</u>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>NO</u> |  |
| 16b. SOCIAL SECURITY NO<br><u>214-38-8885</u>  |  | 17. INFORMANT<br><u>CARVILLE LAUENSTEIN</u>   |  | 17a. ADDRESS<br><u>1708 OLD EASTERN AVE</u>                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u><br><u>436-</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/9</u> 19 <u>80</u> , to <u>9/9</u> 19 <u>80</u> , that (I) (we) <input checked="" type="radio"/> saw the deceased alive on <u>9/9</u> 19 <u>80</u> , and that in <input checked="" type="radio"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) <input type="radio"/> did not view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE<br><u>B.K. Yorkoff, MD</u>  |  | DEGREE<br><u>MD</u>   |  | 22c. DATE SIGNED<br><u>9/2/80</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Yorkoff, MD</u>  |  | 22e. ADDRESS<br><u>Multi-medical 7700 York Rd</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>BURIAL</u>   |  | 23b. DATE<br><u>SEPTEMBER 13, 1980</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>OAK LAWN</u>                             |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>BALTO BALTO MD</u>  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>SEP 15 1980</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Pistone</u>                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><u>CONNELLY FUNERAL HOME 300 MACE AVE</u>  |  |   |  |   |  |



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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 0 2 2 2 2 3  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Harry Thomas LECOMPTE   |  |   |  | 2a. DATE OF DEATH<br>September 25, 1980  |  | 2b. HOUR<br>5:20 P M   |  |
| 3. SEX<br>male  |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH<br>July 1, 1908   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>          |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville 21237  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Die Setter   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>American Can Co   |  |
| 13a. STATE<br>Maryland  |  |   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Essex   |  |
| 14. FATHER'S NAME<br>George - LeCompte  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>Margaret - ?   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>216 03 5408   |  | 17. INFORMANT<br>Marie LeCompte, wife Same   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>1509 IMMEDIATE CAUSE (a) Cardiorespiratory arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Esophageal carcinoma<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 25, 1980, to September 25, 1980, that <input checked="" type="checkbox"/> (we) lost the deceased alive on September 25, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Hattie M. Faison MD   |  |   |  | 22c. DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22d. DATE SIGNED<br>9/25/80  |  |
| 22e. ADDRESS<br>9000 Franklin Square Dr., 21237   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>9-27-80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore County, Maryland   |  |
| 24. FUNERAL DIRECTOR<br>Bruzdzinski Funeral Home PA 1407 Old Eastern Ave  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 30 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>Rita McCreedy  |  |

(M)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 2 2 4

REG. NO.

|  |  |   |   |   |  |   |  |  |  |
|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John Authur LEGERE  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>September 18, 1980 |   |  | 2b. HOUR<br>10:55 P.M.  |  |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>CAUCASIAN  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>08 20 1895  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MASSACHUSETTS   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>ROSSVILLE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQUARE HOSPITAL |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SEA CAPTAIN                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>SHIPPING                      |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND |  |   |   | 13b. CITY OR TOWN<br>BALTIMORE  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13d. STREET ADDRESS<br>5713 TRUMPS MILL RD.                        |  |
| 14. FATHER'S NAME<br>14a. FIRST<br>ANDRE<br>14b. MIDDLE<br>14c. LAST<br>LEGERE   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>15a. FIRST<br>DINA<br>15b. MIDDLE<br>15c. LAST<br>-----   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>WW I<br>217145126   |   | 17. INFORMANT<br>ADDRESS<br>MURIEL MAY 5713 TRUMPS MILL RD.   |  |   |  |  |  |

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BYAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

496 - IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF End Stage of Chronic

(b) Obstructive Pulmonary Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from September 12, 19 80, to September 18, 19 80, that (we) lost<br>saw the deceased alive on September 18, 19 80, and that in (our) opinion death occurred on the date and hour and from the causes stated<br>above, (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Angel Vento   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>9/18/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Angel Vento  |  |  |  | 22e. ADDRESS<br>9000 Franklin Square Drive 21237   |  |   |  |

|   |  |                      |  |   |  |   |  |
|---|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                           |  | 23b. DATE<br>9/22/80 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLLY HILLS |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. BALTO. MD. |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>J. H. Cook<br>ADDRESS<br>12115 Reservoir Ave. |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 23 1980      |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                       |  |



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1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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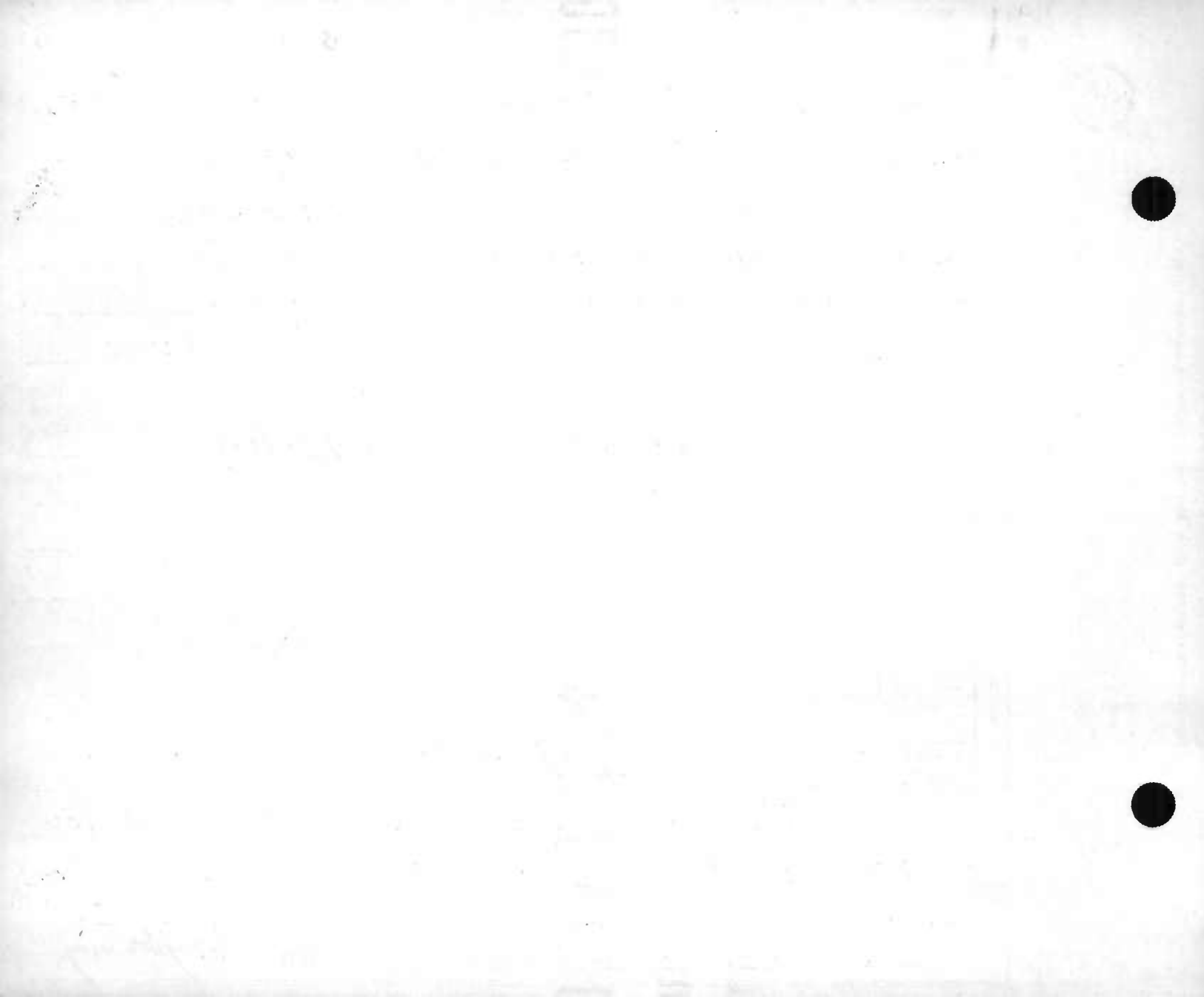
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REG. NO.

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|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Franziska K Hendle</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9-21-80</b>   |  | 2b. HOUR<br><b>845 AM</b>   |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 28 91</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Germany</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Germany</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Manor Care - Rossville</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Florist</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Middle River</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Anthony Seitz</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Crescenz Muhlbock</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>433-15-5676</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs Jolanda Dumps Same</b>                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of colon</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (X) this hospital attended the deceased from <b>6/13/1980</b> , to <b>9/1/1980</b> , that (X) (we) last saw the deceased alive on <b>9/1/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>M. J. Tun</b>   |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>9/1/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KHIN M. TUN</b>  |  | 22e. ADDRESS<br><b>2110 Pot Spring Road Balto Md 21093</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>9/23/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount</b>   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  | 23e. DATE REC'D. BY REGISTRAR<br><b>SEP 22 1980</b>   |  | 23f. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc.</b>   |  | ADDRESS<br><b>Baltimore, Maryland</b>   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

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REG. NO.

|   |  |  |   |   |  |   |  |   |  |
|---|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JENNIE LEVINSKY</b>                           |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 04 80</b> |   |  | 2b. HOUR<br><b>4:00A</b> M.   |  |   |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 2, 1898</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Poland</b>                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N. CHARLES ST.</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                 |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |  |   |   |  |   |  |   |  |
| 13a. STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>601 Coventry Road</b>                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unk.</b>                                   |  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>- Sobush</b> |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>       |  | 16b. SOCIAL SECURITY NO.<br><b>212 10 1505D</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mr. Edwin Lewinski Rockville, Md.</b>  |  |   |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

**CARDIAC FAILURE**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
**4 DAYS**

4292  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

**ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-4</b> <b>80</b> <b>6-13</b> <b>80</b> , to <b>9-4</b> <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>9-4</b> <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Hu Chen-Sien M.D.</i>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>9/4/80</b>   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HU CHEN-SIEN, M.D.</b>   |  |  |  | 22c. ADDRESS<br><b>6701 N. CHARLES ST.</b>   |  |   |  |

|  |  |                            |  |  |  |  |  |
|--|--|----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                              |  | 23b. DATE<br><b>9/6/80</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mem.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville, Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.</b> |  |                            |  | 25a. DATE REGD. BY REGISTRAR<br><b>SEP 10 1980</b>               |  | 25b. REGISTRAR'S SIGNATURE<br><i>notary</i>                            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|   |  |  |                                   |  |  |
|---|--|--|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |                                   | 2b. HOUR   |  |
| DECEASED NAME (TYPE OR PRINT)   |  | MONTH DAY YEAR   |                                   | HOUR MIN   |  |
| ELEANOR V. LIDDELL  |  | 9 19 80  |                                   | 12:45A   |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)   | 7. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| FEMALE  | WHITE  | MONTH DAY YEAR   | 58 YRS.                           | BALTIMORE COUNTY MD.   |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7c. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                   |  |  |
| Penn  | U.S.A.   |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN N. FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| TOWSON  | 6701 N. CHARLES ST. G.B.M.C.   | ASS. LINE  | Gen. Motors                       |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. INSIDE CITY LIMITS?   | 13c. STREET ADDRESS               |  |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 9624 ALDA DRIVE                   |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |                                   |  |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |                                   |  |  |
| RAYMOND E. SHRIVER  |  | NETTIE E. COULSON  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |                                   | 17. INFORMANT ADDRESS  |  |
| NO  |  | 214 14 8444  |                                   | FAMILY RECORDS   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a). 2028 DUE TO, OR AS A CONSEQUENCE OF (b). GENERALIZED LYMPHOMA DUE TO, OR AS A CONSEQUENCE OF (c).  |  |  |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |                                   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                   | 20a. AUTOPSY?  |  |
|   |  |  |                                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                                   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-19 80 to 9-19 80, that (I) (we) last saw the deceased alive on 9-19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                                   |  |  |
| 22b. SIGNATURE  |  | DEGREE   |                                   | 22c. DATE SIGNED   |  |
| Teh-ching Wang  |  |  |                                   | 9-19-80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |                                   |  |  |
| T. WANG, M.D.   |  | 6701 N. CHARLES ST.  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |                                   | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| BURIAL  |  | 9-22-1980  |                                   | MORELAND M. PARK   |  |
| 24. FUNERAL DIRECTOR NAME   |  | ADDRESS  |                                   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE                       |  |
| EVANS FUNERAL CHAPEL  |  | 8800 HARFORD RD  |                                   | SEP 29 1980  |  |

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TEST OF VIBRATION

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TEST OF VIBRATION

GENERAL INFORMATION

08-21-2





FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

8 0 2 2 2 2 8

|   |   |   |  |   |
|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Charles E. Lilly</b>   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>9/22 1980</b>   |  | 2b. HOUR <b>3:00 A.M.</b>   |
| 3. SEX <b>Male</b>  | 4. RACE <b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>12 18 1895</b>  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>84 YRS.</b>   | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.  |
| 10. CITY OR TOWN OF DEATH <b>Dundalk</b>  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5 Bayside Drive</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Plumber</b>   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE <b>Maryland</b>  |   | 13b. COUNTY <b>Baltimore</b>  | 13c. CITY OR TOWN <b>Dundalk</b>   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>5 Bayside Drive</b> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>George T. Lilly</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Ella Young</b>                                     |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>Yes WW I</b>   |   | 16b. SOCIAL SECURITY NO. <b>216-09-4534</b>   |  | 17. INFORMANT <b>Mildred L. Bertheringham</b><br><b>38 Seaside Dr. Ormond Beach, Fla. 32074</b>                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>410 - } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Chronic Coronary arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |   |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |   |   |  |   |
| ACTUAL SIGNATURE <b>K.S. Ahluwalia</b>  |   | TITLE (SPECIFY) <b>reg. M.D.</b>  |  | DATE SIGNED <b>9/22/80</b>  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>K.S. AHLUWALIA</b>   |   | ADDRESS <b>2112, Dundalk MD 21222</b>   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>  | 23b. DATE <b>9/24/1980</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Duda-Ruck, Inc.</b><br>ADDRESS <b>7922 Wise Ave. Dundalk, Md. 21222</b>   |   | 25a. DATE REC'D. BY REGISTRAR <b>SEP 24 1980</b> 25b. REGISTRAR'S SIGNATURE <b>Anthony K. Brady</b> |  |   |

U.S.S.R.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please retain this certificate at the hospital or with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 22 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |                  |   |  | 8 0 2 2 2 2 9<br>REG. NO.   |  |  |  |                                  |
|---|------------------|---|--|---|--|--|--|----------------------------------|
| 1. DECEASED NAME AKA FIRST <sup>(2)</sup> FRANCES <sup>MIDDLE</sup> A. LAST LION<br>(TYPE OR PRINT) <sup>(1)</sup> MARY F. LION   |                  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>9 - 26 - 1980   |  |  |  | 2b. HOUR<br>5 <sup>55</sup> A.M. |
| 3. SEX<br>FEMALE  | 4. RACE<br>WHITE | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>06 07 09  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  |                                  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |                  | 7c. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.   |  |                                  |
| 10. CITY OR TOWN OF DEATH<br>PARKVILLE  |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Perring Pkwy Nsg. Home |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SECRETARY   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. GOV'T  |  |                                  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. COUNTY ---  |                  |   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |                                  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM --- AARON   |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>BERTHA --- DEAN  |  | 16. ADDRESS<br>S. JOHN LION 226 W. MADISON STREET, 21201  |  |  |  |                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |                  | 16b. SOCIAL SECURITY NO.<br>218-03-7705   |  | 17. INFORMANT<br>S. JOHN LION 226 W. MADISON STREET, 21201  |  |  |  |                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute CVA</u><br>436- <u>Due to, or as a consequence of</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u><br>(c) <u>Assted surgery</u> |                  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |                  |   |  |   |  |  |  |                                  |
| 19a. DATE OF OPERATION  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |                                  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |                                  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alone on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                   |                  |   |  |   |  |  |  |                                  |
| 22b. SIGNATURE<br><u>Gracia V. Peterson</u> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |                  |   |  | 22c. DATE SIGNED<br>9/26/80   |  |  |  |                                  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GRACIA V. PETERSON   |                  |   |  | 22e. ADDRESS<br>2926 E. Cold Spring Ln.   |  |  |  |                                  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |                  | 23b. DATE<br>09-29-80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CREST LAWN MEM. GAR.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>MARRIOTTSTVILLE HOWARD MD.   |  |                                  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.  |                  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>21229<br>SEP 29 1980   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Rickey McCreedy</u>   |  |                                  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 2 3 0

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |   |  |  |  |
|---|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>GLORIA May LLOYD</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 23 '80</b> |   | 2b. HOUR<br><b>6:15A M</b>  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Cauc.</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 21 1943</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>37</b> YRS.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N. CHARLES ST.</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cook</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. Co.</b> |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Towson</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jack Warren Powell</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Virginia Elizabeth Welsh</b>   |  | 13e. STREET ADDRESS<br><b>213 Wilden Drive #21204</b>   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-42-6770</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Larry L. Lloyd 213 Wilden Drive Towson, Md. 21204</b>  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1749 Metastatic Pulmonary Disease</b><br>IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Bilateral Breast CA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-20</b> , 19 <b>80</b> , to <b>9-23</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>9-23</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i><br>DEGREE  |  |  |  | 22c. DATE SIGNED<br><b>9/23/80</b>  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. J. Bergman</b>  |  |  |  | 22e. ADDRESS<br><b>6701 N. Charles St. 21204</b>  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>9/26/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Grace Methodist Cem.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Reisterstown Balto. Md.</b>   |  |  |
| 24. FUNERAL DIRECTOR<br><i>[Signature]</i><br><b>J. E. Lowell Lemmon</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 29 1980</b>   |   | 25b. GEMOLOGIST'S SIGNATURE<br><i>[Signature]</i>  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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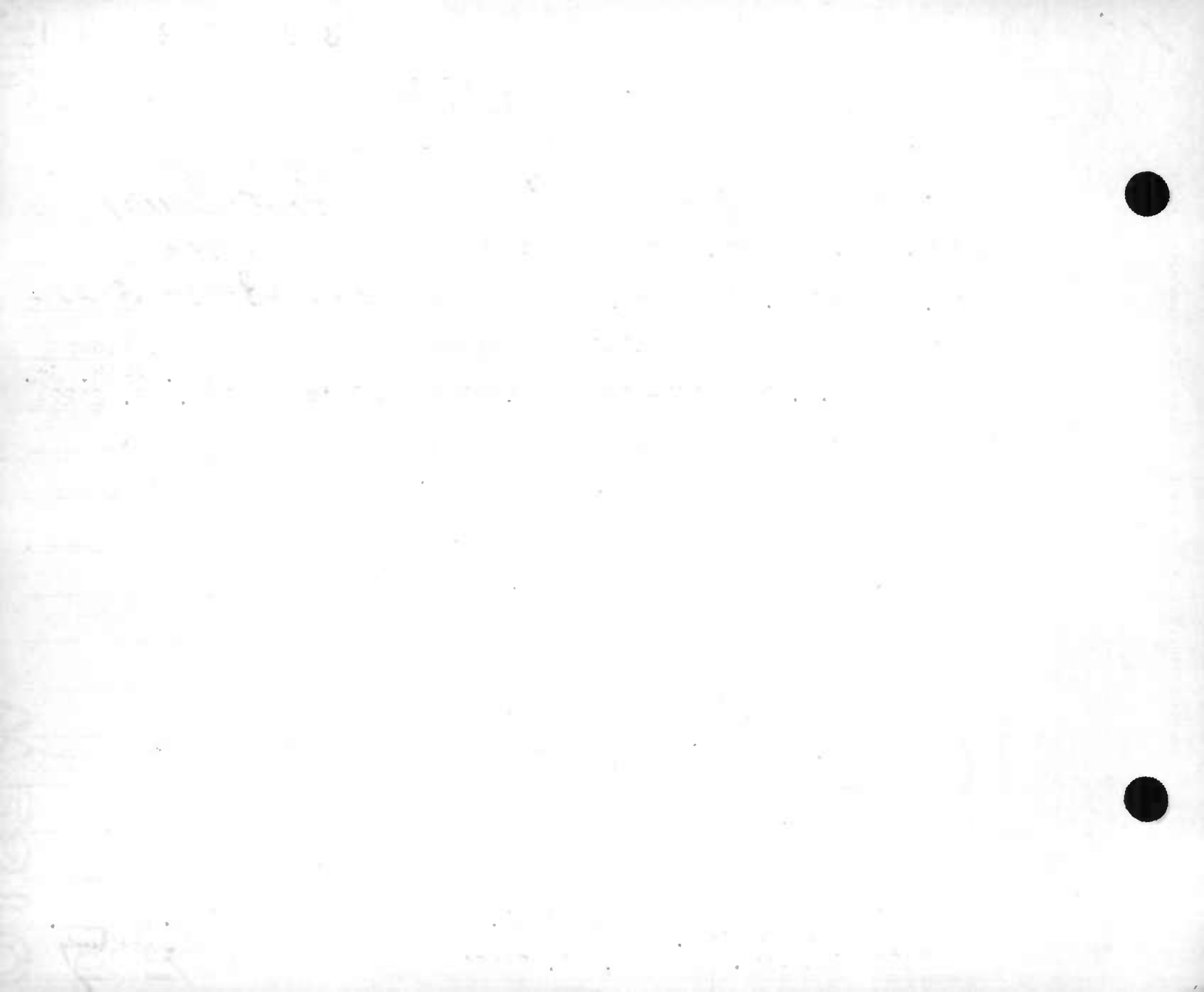
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TO HOSPITALS ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  | 8 0 2 2 2 3 1                 |       |  |          |       |
|--|--|--|--|--|--|---|--|--|--|-------------------------------|-------|--|----------|-------|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |  |  |   |  |  |  |                               |       |  |          |       |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST August   |  | MIDDLE H.  |  | LAST Loeblein   |  | 2a. DATE OF DEATH  |  | MONTH 9                       | DAY 8 | YEAR 80  | 2b. HOUR | 255 A |
| 3 SEX<br>MALE  |  | 4 RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH 5 DAY 20 YEAR 07   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN. |       |  |          |       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. County MD.  |  |  |  |                               |       |  |          |       |
| 10 CITY OR TOWN OF DEATH<br>BALTO., MD.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. JOSEPH HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Monument Dealer  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |                               |       |  |          |       |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE MD.  |  | 13b. CITY OR TOWN<br>Balto.  |  | 13c. CITY OR TOWN<br>Dundalk   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>529 48th St.  |  | 21224                         |       |  |          |       |
| 14 FATHER'S NAME<br>FIRST Joseph   |  | MIDDLE   |  | LAST Loeblein  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST Barbara   |  | MIDDLE   |  | LAST Not Known                |       |  |          |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W. 2  |  | 17 INFORMANT<br>Lorraine Loeblein  |  | ADDRESS<br>529 S. 48th. St.   |  | Balto. Md.   |  | 21224                         |       |  |          |       |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR COLLAPSE</u>   |  |  |  |  |  |   |  |  |  |                               |       | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>2 HOURS |          |       |
| 410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>MYOCARDIAL INFARCTION</u>  |  |  |  |  |  |   |  |  |  |                               |       | 2 HOURS  |          |       |
| (c) <u>CORONARY ARTERY DISEASE</u>   |  |  |  |  |  |   |  |  |  |                               |       | YEARS  |          |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>PERIPHERAL VASCULAR DISEASE / ABDOMINAL ANEURYSM</u>   |  |  |  |  |  |   |  |  |  |                               |       |  |          |       |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                               |       |  |          |       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |                               |       |  |          |       |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |                               |       |  |          |       |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-7-80</u> 19 <u>80</u> to <u>9-8</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>9-8</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |                               |       |  |          |       |
| 22b. SIGNATURE<br><u>Randolph C. Whirps MD</u>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  |   |  | 22c. DATE SIGNED<br><u>9/8/80</u>  |  |                               |       |  |          |       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>RANDOLPH WHIRPS</u>  |  | 22e. ADDRESS<br><u>ST. JOSEPH HOSPITAL</u>   |  |  |  |   |  |  |  |                               |       |  |          |       |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |  | 23b. DATE<br><u>9/11/1980</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Sacred Ht. Jesus</u>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Balto. Md.</u>                                 |  |  |  |                               |       |  |          |       |
| 24 FUNERAL DIRECTOR<br>NAME <u>Duda-Ruck Inc.</u>  |  | ADDRESS<br><u>7922 Wise Ave. Dundalk, Md. 21222</u>  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>SEP 10 1980</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |  |  |                               |       |  |          |       |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |   |  | 8 0 2 2 2 3 2                                 |  |
|---|--|--|--|--|--|---|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |  |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>DONALD  |  | MIDDLE<br>VERNON   |  | LAST<br>LONDON, SR.   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>September 1, 1980  |  | 2b. HOUR<br>3:00 AM                           |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 15, 1925  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>XX 54 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.                |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |  |   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Greater Baltimore Medical Center        |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Vice-President   |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Balto. Chair  |  |   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Maryland  |  |  |  | 13b COUNTY<br>Baltimore  |  | 13c CITY OR TOWN<br>Towson  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e STREET ADDRESS<br>804 Elderbank Ct. 21204 |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Vernon W. London   |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Eulah Price  |  |   |  |   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes WW II  |  | 16b SOCIAL SECURITY NO.<br>217-20-5999   |  | 17 INFORMANT<br>ADDRESS<br>Margaret R. London, 804 Elderbank Ct  |  |   |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br><u>410-</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Coronary Arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <u>Arteriosclerotic Cardiovascular Disease</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Cirrhosis of liver with hepatic failure</u> |  |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>August 15</u> , 19 <u>80</u> , to <u>September 1</u> , 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>September 1</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>John E. Adams, M.D.</u>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>Sept. 1, 1980  |  |   |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John E. Adams, M.D.  |  | 22e. ADDRESS<br>6701 N. Charles Street, Towson, Md. 21204  |  |  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Sept. 4, 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                         |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>ROBERT C. ALTENBURG FUNERAL HOME, INC.<br>6009 Harford Rd., Balto., Md. 21214   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 3 1980   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Patricia Helms</u>   |  |   |  |

80 25 10

SEP 3 1980

Unpublished

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |   |   |   |  |  | 8  | 0 | 2   | 2                                 | 2                              | 3 | 3 |
|--|--|--|--|--|---|---|---|--|--|--|---|---|-----------------------------------|--------------------------------|---|---|
| 1 - FOR STATE REGISTRAR  |  |  |  |  |   |   |   |  |  | REG. NO.   |   |   |                                   |                                |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Bernard E. Louden</b>   |  |  |  |  |   |   |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 30, 1980</b>   |   |   |                                   | 2b. HOUR<br><b>8:20P.M.</b>    |   |   |
| 3. SEX<br><b>Male</b>  |  |  | 4. RACE<br><b>White</b>  |  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 21, 1903</b>   |   |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>77</b> YRS.  |  |   | IF UNDER 1 YEAR<br>MONTHS DAYS                                      |                                   | IF UNDER 24 HRS.<br>HOURS MIN. |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |   |   |                                   |                                |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County Gen. Hospital</b> |  |   |   |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Baltimore Transit</b> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY |                                |   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Glyndon</b>   |  |  |  |  |   |   |   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |   | 13e. STREET ADDRESS<br><b>52 Waugh Ave.</b>                         |                                   |                                |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George H. Louden</b>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Agnes Price</b> |   |   |  |  |  |   |   |                                   |                                |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>215-09-3815</b>   |  |   | 17. INFORMANT<br>ADDRESS<br><b>Mildred M. Louden Glyndon</b>  |   |  |  |  |   |   |                                   |                                |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line of (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4409</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerosis - generalized</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>Anemia - C/V</b> |  |  |  |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Minutes</b><br><b>Years</b><br><b>2 months</b>    |   |   |                                   |                                |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |   |   |   |  |  |  |   |   |                                   |                                |   |   |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |   |                                   |                                |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |   |   |                                   |                                |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |   |   |                                   |                                |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-19</b> , 19 <b>77</b> , to <b>9-30</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>9-30</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |  |  |  |  |   |   |   |  |  |  |   |   |                                   |                                |   |   |
| 22b. SIGNATURE<br><b>C. E. McWilliams</b> M.D.<br>22c. DATE SIGNED<br><b>10-1-80</b>   |  |  |  |  |   |   |   |  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. E. McWilliams</b>                                     |   | 22e. ADDRESS<br><b>11904 Reisterstown Rd, Reisterstown Md 21136</b> |                                   |                                |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>I SPECIFY <b>Burial</b>   |  |  | 23b. DATE<br><b>Oct, 3, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Reisterstown Methodist</b> |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Reisterstown Balto. Md.</b> |  |  |   |   |                                   |                                |   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Eline Funeral Home Reisterstown, Md.</b>  |  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 3 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>History McLeod</b>                          |  |  |   |   |                                   |                                |   |   |

MEDICAL CERTIFICATION

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |   |   |   |   |   |                         |   |  | REG. NO. 22234  |  |
|---|-------------------------|---|---|---|---|---|-------------------------|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOSEPH EDWARD MAGROGAN</b>   |                         |   |   |   |   |   |                         |   |  | 2b. DATE KNOWN OF DEATH<br>ESTIMATED <b>9 19 1980</b>                               |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>2/20/1906</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.  | 2c. DATE PRONOUNCED DEAD<br><b>9 19 1980</b>  | 2d. HOUR<br><b>1230</b> |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>                                 |                         |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1417 Vesper Avenue</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dye Cutter</b>              |                         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Tele Equip. Mfrgr.</b>          |  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                         |   |   |   |   |   |                         |   |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |                         | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Dundalk</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                         | 13e. STREET ADDRESS<br><b>1417 Vesper Ave. 21222</b>                    |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Edward Magrogan</b>   |                         |   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Theresa Unknown</b> |   |                         |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |                         |   | 16b. SOCIAL SECURITY NO.<br><b>217.01.2274</b>    |   | 17. INFORMANT ADDRESS<br><b>Edna Magrogan (Wife) Same as 13e</b>        |   |                         |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic ischemic myocardial disease</b><br><b>4148</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |   |   |   |   |   |                         |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |                         |   |   |   |   |   |                         |   |  |   |  |
| 19a. DATE OF OPERATION  |                         |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |                         |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |                         |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                         |   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                         |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |   |   |   |   |                         |   |  |   |  |
| ACTUAL SIGNATURE <b>J. Crossan O'Donovan</b>  |                         |   |   | TITLE (SPECIFY) <b>Deputy</b>   |   |   |                         | DATE SIGNED <b>9/19/80</b>  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>J. CROSSAN O'DONOVAN</b>   |                         |   |   | ADDRESS <b>2112 DUNDALK AVE, BALTO, MD 21222</b>  |   |   |                         |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>9/22/1980</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gds. of Faith Cemetery</b>   |   |   |                         | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Walter Brooks Bradley, Inc., Dundalk, Md. 21222</b>  |                         |   |   |   |   | 25a. RECEIVED BY REGISTRAR<br><b>SEP 25 1980</b>  |                         | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                        |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Rebecca Ann Malcolm  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>September 8, 1980            |  | 2b. HOUR<br>6:23 P.M.  |
| 3. SEX<br>FEMALE   | 4. RACE<br>CAUC.   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 8 80  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br>11                             | IF UNDER 1 YEAR<br>IF UNDER 24 HRS<br>HOURS MIN  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph's Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD. 13b. COUNTY BALTIMORE   |  |   | 13c. CITY OR TOWN<br>BALTIMORE                                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>BARRY EDWARD MALCOLM   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY SUSAN SHINSKY |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>-   |   | 17. INFORMANT<br>ADDRESS<br>BARRY MALCOLM 6902 EAST BROOKE                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Prematurity<br>7651<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (this hospital) attended the deceased from September 8, 19 80, to September 8, 19 80, that (we) lost<br>saw the deceased alive on September 8, 19 80, and that in (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I/we) (did) (did not) view the body after death.   |  |   |   |  |  |
| 22b. SIGNATURE<br>H. S. Crist, MD  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br>9-9-80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Henry S. Crist, M.D.  |  | 22e. ADDRESS<br>7620 York Rd. Towson, Md. 21204   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   | 23b. DATE<br>9/10/80   | 23c. NAME OF CEMETERY OR CREMATORY<br>GARDENS OF FAITH  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD.                          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>O. DABROWSKI 450N 387 E BALTIMORE ST.  |  | ADDRESS<br>18 1980  |   | 25. BY (YEAR) 26. REGISTRAR (SIGNATURE)  |  |

MEDICAL CERTIFICATION



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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 2 3 6

REG. NO.

|  |   |   |   |   |  |  |  |   |
|--|---|---|---|---|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>LEWIS   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>SEPT. 15, 1980   |   |  | 2b. HOUR<br>1:25 A.M.  |  |   |
| 3 SEX<br>MALE  | 4 RACE<br>WHITE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>NOV. 4, 1895  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.  |   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD. |  |  |   |
| 10. CITY OR TOWN OF DEATH<br>RANDALLSTOWN  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>RANDALLSTOWN CONVALESCENT CENTER |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SELF-EMPLOYED |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>FURNITURE |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND   |   |   | 13b. COUNTY   |   |  | 13c. CITY OR TOWN<br>BALTIMORE   |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>MAX MANDEL   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LOTTIE UNKNOWN                                   |   |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWI-ARMY 213-28-7133                   |   |  | 17. INFORMANT<br>MRS. JEAN MANDEL<br>6400 APOLLO DR., APT. D #21209                  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pneumonia</i><br>DUE TO, OR AS A CONSEQUENCE OF <i>End Stage Parkinson's dis.</i><br>DUE TO, OR AS A CONSEQUENCE OF <i>Chronic obstructive lung dis.</i><br>3320<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>2 days</i><br><i>3 y.</i> |   |   |   |   |  |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |   |   |   |   |  |  |  |   |
| 19a. DATE OF OPERATION<br><i>9/11/80</i>   |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>AT HOME <input checked="" type="checkbox"/> AT WORK  |   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                            |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |
| 22a. I certify that (i) (this hospital) attended the deceased from <i>9/11/80</i> to <i>9/15/80</i> that (i) I am not aware of the deceased after <i>9/15/80</i> and that in (my) opinion death occurred on the date and hour and from the causes stated above (i) I have not (did not) view the body after death.   |   |   |   |   |  |  |  |   |
| 22b. SIGNATURE<br><i>Christian Mass</i><br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |   |   |   |   |  | 22c. DATE SIGNED<br><i>9/16/80</i>   |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. CHRISTIAN MASS  |   |   |   |   |  | 22e. ADDRESS<br>413 NOTTINGHAM RD.   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) BURIAL  |   |   | 23b. DATE<br>SEPT. 16, 1980   |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>OHEL YAKOV                                     |  |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND   |   |   | 23e. NAME OF FUNERAL HOME<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215 |   |  |  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |   |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 19 1980   |  |   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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SEP 1 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |                                     |   |  |  | REG. NO. 80 22237                            |  |  |  |
|---|-------------------------------------|---|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Thelma S. MANNER   |                                     | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>September 7 1980   |  | 2b. HOUR<br>8:45p M  |  |  |  |  |
| 3. SEX<br>Female  | 4. RACE<br>White                    | 5. DATE OF BIRTH<br>July 1, 1908 YEAR   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.   |  |  |  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN)<br>Baltimore, Md.  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville 21237  |                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>Franklin Sq. Hospital  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MAIN WORKING LIFE)<br>Housewife  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>Maryland  |                                     | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13c. STREET ADDRESS<br>2262 Monocacy Rd.   |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Souders  |                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>?  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |                                     | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212 44 8954  |  | 17. INFORMANT<br>9535 Buckboard Lane<br>Eugene Manner, Son Baltimore, Md. 21220  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiopulmonary arrest<br>2396<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) probable brain tumor<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |                                     |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |
| 19a. DATE OF OPERATION  |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from August 13, 1980, to Sept 7, 1980, that (we) last saw the deceased alive on Sept 7, 1980, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.   |                                     |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Amin N. Daghi   |                                     | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>9/7/80   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. A. Daghestani  |                                     | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237   |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial   |                                     | 23b. DATE<br>9/11/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery  |  |  |  |  |
| 23d. LOCATION<br>CITY OR TOWN<br>Baltimore, Md.   |                                     | 23e. COUNTY<br>Baltimore  |  | 23f. STATE<br>Md.  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Gruzdzinski Funeral Home PA 1407  |                                     | 25a. DATE REC'D. BY REGISTRAR<br>SEP 8 1980   |  | 25b. SIGNATURE<br>[Signature]  |  |  |  |  |

8-0-55321



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

FOR  
1 - STATE  
REGISTRAR

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>VINCENT m Robert MARANTO</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 19, 1980</b>  |   | 2b. HOUR<br><b>12 PM</b>   |   |
| 3 SEX<br><b>Male</b>  | 4 RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 - 9 - 1920</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS.                                    |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1500 Dulaney Valley Road</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman - Quality</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Brands</b>                  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |  |   |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Towson</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1500 Dulaney Valley Road</b>              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Maranto</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Jenny DiFatta</b>   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII 219-01-0317</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Louise Maranto same as # 13</b>                  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1539 Carcinoma of Colon.</b><br>IMMEDIATE CAUSE (a) <b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>11-12 months</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                    |  |   |   |  |   |
| 22b. SIGNATURE<br><b>Lester A. Wall, Jr. M.D.</b>   |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>9/19/80</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lester A. Wall, Jr. M.D.</b>  |  | 22e. ADDRESS<br><b>1502 Dulaney Valley Road</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Entombment</b>  |  | 23b. DATE<br><b>Sept. 22, 1980</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mausoleum</b>                |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville Balto., Md.</b>   |  | 23e. DATE REC'D. BY REGISTRAR   |   | 23f. REGISTRAR'S SIGNATURE<br><b>Lester A. Wall, Jr.</b>                             |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>   |  | 24b. DATE REC'D. BY REGISTRAR   |   | 24c. REGISTRAR'S SIGNATURE<br><b>SEP 22 1980</b>                                     |   |

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 2 3 9

REG. NO.

|   |  |  |   |   |  |   |  |
|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ZITA T. MARTIN  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>SEPTEMBER 6, 1980 |   |  | 2b. HOUR<br>7:25 P.<br>M.   |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>AUGUST 12, 1882   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>98 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |  |
| 10. CITY OR TOWN OF DEATH<br>CATONSVILLE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FOREST HAVEN NURSING HOME |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SEAMSTRESS                  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |   |   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |   |  |   |  |
| 13a. STATE<br>MD.   |  | 13b. COUNTY<br>BALTIMORE   |   | 13c. CITY OR TOWN<br>RANDALLSTOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET ADDRESS<br>714 SHELLEY RD. 21204  |  |  |   |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>RICHARD A. MARTIN   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SUSAN M. SMITH   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-34-2523   |   | 17. INFORMANT<br>ADDRESS<br>JOSEPH POWERS 714 SHELLEY RD. 21204   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Multiple Strokes</u><br>436-   |  |  |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><u>45yr - Infantile Cerebral</u>  |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 1978</u> to <u>Sept 6, 1980</u> , that (I) (we) last saw the deceased alive on <u>Sept 2, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br><u>[Signature]</u>  |  |  |   | DEGREE  |  | 22c. DATE SIGNED<br>9-8-80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Harold Bob</u>  |  |  |   | 22e. ADDRESS<br><u>7220 Park Heights 21208</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>9/9/1980  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>St. IGNATIUS  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>HICKORY HARBOR MD.                                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212   |  |  |   | 24. FUNERAL DIRECTOR<br>ADDRESS   |  |   |  |



8 0 3 3 3 3 3

DATE: 10/10/1950

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 2 2 4 0

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>George C. Martini  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>Sept. 19, 1980  |  | 2b. HOUR p<br>7:40 M   |
| 3. SEX<br>Male  | 4. RACE<br>White                       | 5. DATE OF BIRTH MONTH DAY YEAR<br>2-28-21  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                              |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph Hospital                               |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Self-Employed       | 12b. KIND OF BUSINESS OR INDUSTRY<br>Arnold Bakers   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. ST. <u>Ma.</u> 13b. COUNTY <u>Balto.</u> 13c. CITY OR TOWN <u>Towson</u>   |  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Joseph Martini   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary De Sio                                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE NUMBER OR DATES)<br>068-14-5170  | 17. INFORMANT ADDRESS<br>Mrs. Elaine A. Martini - 204 E. Joppa Rd. 604 Hampton House Apt. |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hepato Renal Failure, Metastatic Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Liver, Lung, Mesenteric Nodes</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Sept. 2, 1980</u> to <u>Sept. 19, 1980</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Sept. 19, 1980</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.  |  |   |   |  |  |
| 22b. SIGNATURE<br>Jose S. de Leon   |  | DEGREE  |   | 22c. DATE SIGNED<br>9/19/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOSE S. DE LEON  |  | 22e. ADDRESS<br>ST. JOSEPH HOSPITAL, TOWSON, MD.  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   | 23b. DATE<br>9-23-80                   | 23c. NAME OF CEMETERY OR CREMATORY<br>Greenwood Cem.  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Brooklyn, New York                        |  |
| 24. FUNERAL DIRECTOR NAME<br>John C. Miller Inc-6415 Belair Rd.-21206   |  | ADDRESS   |   | 25a. DATE REC'D. BY REGISTRAR<br>SEP 24 1980   | 25b. REGISTRAR'S SIGNATURE<br>Jeffrey H. Brady   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



St. Joseph Hospital

Tomb

Cardiac Transplant Laboratory

George Washington University

University of Maryland

Sept. 10, 1977

Sept. 10, 1977

Sept. 10, 1977

Sept. 10, 1977

Sept. 10, 1977

Sept. 10, 1977

Sept. 10, 1977

Sept. 10, 1977



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 80 22241   |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2r. DATE OF DEATH  |  |  |  | 2b. HOUR   |  |  |  |
| Marie Mamie Mattheu  |  |  |  | September 13, 1980   |  |  |  | 11:35P <sub>M</sub>  |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR   |  | 7. IF UNDER 24 HRS   |  |
| M  |  | W  |  | 1 10 02  |  | 78 YRS   |  | MONTHS   |  | DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |  |  |
| MD.  |  | USA  |  |  |  | Baltimore County MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| ESSEX  |  | FRANKLIN SQ. HOSP.   |  |  |  |  |  | NO   |  | —  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS  |  |
| MD   |  |  |  | BALTO  |  | ESSEX  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 1520 NICHOLAY WAY  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |
| JAMES HANZLIK  |  |  |  | CATHERINE SPITOLSKY  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |  |  |  |  |
| NO   |  |  |  | 216-42-3177  |  | ROSE MARY MATTHEW ABOVE  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiogenic Shock  |  |  |  |  |  |  |  |  |  |  |  |
| 410- DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction  |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |  |
|  |  |  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |  |  |
|  |  |  |  | P.M. 19  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION  |  |  |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  |  |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from August 20, 1980, to September 13, 1980, that (I) (we) last saw the deceased alive on September 13, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| Samuel J. Westrick MD  |  |  |  |  |  |  |  |  |  | 9/13/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |
| Samuel J. Westrick, M.D.   |  |  |  | 9000 Franklin Square Drive 21237   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |  |  |
| BURIAL   |  |  |  | 9/16/80  |  | OAK LAWN   |  | CITY OR TOWN BALTO COUNTY MD.  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25. DATE REC'D. BY REGISTRAR   |  |  |  | 25. REGISTRAR'S SIGNATURE  |  |  |  |
| NAME CONNELLY F.H.   |  |  |  | ADDRESS 300 MACE AVE   |  |  |  | SEP 19 1980  |  |  |  |

U.S. 8 0



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18

THE  
JAMES  
W. RICHARDSON  
JAMES RICHARDSON  
JAMES RICHARDSON

8/13/68

18

259 18 1800

ITEMS #13a-13e, 11&23b Film G548  
 10/1/80 rc  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 22242

|  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                  |  |  |  |  |  |          |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
|--|--|--|--|--|--|---|--|--|---|--|--|---|--|--|------------------|--|--|--|--|--|----------|--|--|---|--|--|--|--|--|--|--|--|--|--|--|------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST  |  |  | MIDDLE  |  |  | LAST  |  |  | 2a. DATE KNOWN OF DEATH                                     |  |  | MONTH            |  |  | DAY  |  |  | YEAR     |  |  | 2b. HOUR  |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| Timothy Jay Matthews   |  |  |  |  |  |   |  |  |   |  |  | 9   |  |  | 14               |  |  | 19   |  |  | 80       |  |  | M   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| 3. SEX   |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH  |  |  | 6. AGE (IN YEARS)   |  |  | IF UNDER 1 YR.  |  |  | IF UNDER 24 HRS. |  |  | 7c. DATE PRONOUNCED DEAD                     |  |  | 2d. HOUR |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| Male   |  |  | White  |  |  | 10 30 1958  |  |  | 21 YRS.   |  |  |   |  |  |                  |  |  | 9 14 1980                                    |  |  | 10:40    |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?                             |  |  | 8. Separated  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |   |  |  |                  |  |  |  |  |  |          |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| Colorado   |  |  | USA  |  |  | Baltimore County  |  |  |   |  |  |   |  |  |                  |  |  |  |  |  |          |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |   |  |  |                  |  |  |  |  |  |          |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| Baltimore  |  |  | Rt. 695 at northbound I83                                |  |  | Shipping Sup.   |  |  | Glowe Co.   |  |  |   |  |  |                  |  |  |  |  |  |          |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| 13a. STATE   |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?  |  |  | 13e. STREET ADDRESS   |  |  |                  |  |  |  |  |  |          |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| Maryland   |  |  | Worcester  |  |  | Ocean City  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 149 Old Wharf Road,   |  |  |                  |  |  |  |  |  |          |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME                                 |  |  |   |  |  |   |  |  |   |  |  |                  |  |  |  |  |  |          |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| Edward P. Matthews Jr.   |  |  | Emma M. Sipes  |  |  |   |  |  |   |  |  |   |  |  |                  |  |  |  |  |  |          |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  |  | 16b. SOCIAL SECURITY NO.                                 |  |  | 17. INFORMANT (father) ADDRESS                                |  |  |   |  |  |   |  |  |                  |  |  |  |  |  |          |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| no   |  |  | 215-78-6673  |  |  | Edward P. Matthews-(same as 13e)                              |  |  |   |  |  |   |  |  |                  |  |  |  |  |  |          |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |          |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| PART 1 DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                  |  |  |  |  |  |          |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| IMMEDIATE CAUSE (a) Multiple injuries  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                  |  |  |  |  |  |          |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                  |  |  |  |  |  |          |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                  |  |  |  |  |  |          |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| (b)  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                  |  |  |  |  |  |          |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                  |  |  |  |  |  |          |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| (c)  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                  |  |  |  |  |  |          |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                  |  |  |  |  |  |          |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |   |  |  |   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |  |                  |  |  |  |  |  |          |  |  | 20. AUTOPSY?  |  |  |  |  |  |  |  |  |  |  |  |                              |  |
|  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                  |  |  |  |  |  |          |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  |  |  |   |  |  |   |  |  | 21b. TIME OF INJURY   |  |  |                  |  |  |  |  |  |          |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| 0:30 M. 9 14 1980  |  |  |  |  |  |   |  |  |   |  |  | pedestrian struck by autos                                  |  |  |                  |  |  |  |  |  |          |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK  |  |  |  |  |  |   |  |  |   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |  |                  |  |  |  |  |  |          |  |  | 21f. LOCATION   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| street   |  |  |  |  |  |   |  |  |   |  |  | Rt. 695 at northbound I-83                                  |  |  |                  |  |  |  |  |  |          |  |  | Balto. Co., MD.   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                  |  |  |  |  |  |          |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| ACTUAL SIGNATURE   |  |  |  |  |  |   |  |  |   |  |  | TITLE (SPECIFY)   |  |  |                  |  |  |  |  |  |          |  |  | DATE SIGNED   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| Thomas D. Smith  |  |  |  |  |  |   |  |  |   |  |  | Deputy Chief  |  |  |                  |  |  |  |  |  |          |  |  | 9/15/80   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |  |  |  |  |   |  |  |   |  |  | ADDRESS   |  |  |                  |  |  |  |  |  |          |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| Thomas D. Smith, M.D.  |  |  |  |  |  |   |  |  |   |  |  | 111 Penn St. Balto., MD.                                    |  |  |                  |  |  |  |  |  |          |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  |  |  |   |  |  |   |  |  | 23b. DATE   |  |  |                  |  |  |  |  |  |          |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |  |  |  |  |  |  |  |  |  | 23d. LOCATION                |  |
| Burial   |  |  |  |  |  |   |  |  |   |  |  | 9-17-1980   |  |  |                  |  |  |  |  |  |          |  |  | Gate of Heaven  |  |  |  |  |  |  |  |  |  |  |  | Silver Spring Montgomery Md. |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |   |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR                               |  |  |                  |  |  |  |  |  |          |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| Warner E. Pumphrey, Inc.   |  |  |  |  |  |   |  |  |   |  |  | SEP 22 1980   |  |  |                  |  |  |  |  |  |          |  |  | [Signature]   |  |  |  |  |  |  |  |  |  |  |  |                              |  |
| 8434 Ga. Ave., S.S. Md.  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                  |  |  |  |  |  |          |  |  |   |  |  |  |  |  |  |  |  |  |  |  |                              |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.



U.S. 58 930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  | 80 | 22 | 24 | 3 |
|--|--|--|--|---|--|---|--|---|--|----|----|----|---|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |   |  |   |  |    |    |    |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>MARIE Ward MAYHEW</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>9 30 80</b>  |  |   |  | 2b. HOUR<br><b>5:00A<sub>M</sub></b>  |  |    |    |    |   |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>March 20, 1925</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |    |    |    |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>South Carolina</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>   |  |   |  |    |    |    |   |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH A CITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N. CHARLES ST.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Employee of Carr-Lowery Glass Co.</b>     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |    |    |    |   |
| 13a. STATE<br><b>Maryland</b>  |  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |    |    |    |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Herbert Ward</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Olympis Livingston</b>   |  |   |  |   |  |    |    |    |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>250-34-0633</b>  |  | 17. INFORMANT ADDRESS<br><b>Baltimore, Maryland 21230</b><br><b>Mr. Amer J. Mayhew, Jr. 902 Maisel Street</b> |  |   |  |    |    |    |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br><b>CARDIO RESPIRATORY ARREST</b><br>IMMEDIATE CAUSE (a) _____<br><b>1629</b> DUE TO, OR AS A CONSEQUENCE OF<br><b>METASTATIC CA OF LUNG</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ |  |  |  |   |  |   |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  |    |    |    |   |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |    |    |    |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |  |   |  |   |  |    |    |    |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                 |  |   |  |    |    |    |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |    |    |    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-13</b> , 19 <b>80</b> , to <b>9-30</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>9-30</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |   |  |    |    |    |   |
| 22b. SIGNATURE<br><b>P.J. Patel</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>9-30-80</b>  |  |    |    |    |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>P.J. PATEL, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>GBMC-6701 N. CHARLES ST.</b>   |  |   |  |   |  |    |    |    |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>10/4/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Anne Arundel Md.</b>  |  |    |    |    |   |
| 24. FUNERAL DIRECTOR NAME<br><b>Mc Cully Funeral Home of Brooklyn</b><br><b>237 E. Patapsco Avenue Baltimore, Md. 21225</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 2 1980</b>  |  | 25b. HEALTH OFFICIAL'S SIGNATURE<br><b>R. J. Brady</b>  |  |   |  |    |    |    |   |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 2 4 4  
REG. NO.

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Dorothy I. McAloon</i>  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>9-13-80</i>   |   | 2b. HOUR<br><i>1:40 AM</i>  |  |
| 3. SEX<br><i>Female</i>  | 4. RACE<br><i>White</i>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>9-29-21</i>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>58</i> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Md.</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.                             |  |
| 10. CITY OR TOWN OF DEATH<br><i>Towson</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Box 132 (Timonium, Md.)</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Secy</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Balkers &amp; Caf. Workers</i> |
| 13a. STATE<br><i>Towson Md.</i>  |   | 13b. COUNTY<br><i>Balto.</i>  | 13c. CITY OR TOWN<br><i>Towson</i>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Arthur R. Davis</i>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Rosa E. Batenfeld</i>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |   | 16b. SOCIAL SECURITY NO.<br><i>212-14-3396</i>  |   | 17. INFORMANT<br>ADDRESS<br><i>Mrs. Elizabeth C. Holland - 4606 Bayonne Ave. 21206</i>          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Chorocarcinoma</i><br><i>1629</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastasis</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (c) |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>With</i>            |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>June 9/1/80</i> 19 <i>52</i> to <i>9/13/80</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>9/1/80</i> 19 <i>80</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)       |   |   |   |   |  |
| 22a. SIGNATURE<br><i>Thomas L. Worsley MD</i>  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22b. DATE SIGNED<br><i>9/15/80</i>  |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>THOMAS L. WORSLEY</i>  |   | 22d. ADDRESS<br><i>6505 YORK ROAD</i>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |   | 23b. DATE<br><i>9-16-80</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Bel Air Memorial Gardens</i>                           |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Bel Air Md.</i>   |   | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>John C. Miller Inc-6415 Belair Rd.-21206</i>   |   | 25. DATE RECEIVED BY REGISTRAR<br><i>SEP 15 1980</i>  |  |

MEDICAL CERTIFICATION



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 0 2 2 2 4 5  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>RUTH AGNES McARTHUR</b>   |  |   |  | 2a DATE OF DEATH<br>MONTH <b>9</b> DAY <b>28</b> YEAR <b>80</b>  |  |  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>8</b> YEAR <b>1924</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MA</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 13a STATE<br><b>MD</b>  |  | 13b COUNTY<br><b>Baltimore</b>  |  | 13c CITY OR TOWN<br><b>Woodlawn</b>  |  | 13e STREET ADDRESS<br><b>7017 Dogwood Road</b>   |  |
| 14 FATHER'S NAME<br>FIRST <b>Augustus</b> MIDDLE <b>Avenell</b> LAST <b>Keenan</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ruth</b> MIDDLE <b>Keenan</b> LAST <b>Keenan</b>  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b SOCIAL SECURITY NO.<br><b>022-12-8234</b>   |  | 17 INFORMANT<br><b>Mr. Ross McArthur</b> ADDRESS<br><b>7017 Dogwood Rd., Baltimore, MD 21207</b>   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial infarction</b><br><b>410 -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/28/80</b> , 19 <b>80</b> , to <b>9/28/80</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>9/28/80</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>D. BEARD</b>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |  | 22c. DATE SIGNED<br><b>9/28/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D. BEARD</b>  |  |   |  | 22e. ADDRESS<br><b>5401 Old Court Rd., Randallstown, MD 21133</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10/2/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Memorial Pk.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sykesville Carroll MD</b>   |  |
| 24 FUNERAL DIRECTOR<br>NAME <b>Loring Byers Funeral Directors, P.A.</b><br><b>8728 Liberty Rd., Randallstown, MD 21133</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 30 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |



*Handwritten text, possibly a signature or name, in the center of the page.*

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 2 2 4 6

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |   |  |   |  |  |
|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Sister Mary Constantine McEtrick</b>   |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 26 1980</b>                                   |  | 2b. HOUR<br><b>2 a.m.</b>  |
| 3 SEX<br><b>FEMALE</b>   | 4 RACE<br><b>WHITE</b>  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 30 1892</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS<br>IF UNDER 1 YEAR: MONTHS DAYS<br><b>4</b>              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK CITY</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                                       |  |
| 10 CITY OR TOWN OF DEATH<br><b>Stevenson Md.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Villa Julie Infirmary</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TEACHER</b>        | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>EDUCATION</b>  |  |
| 13a. STATE RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Maryland</b>  |   | 13b. Baltimore   | 13c. CITY OR TOWN<br><b>SAME AS #11</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          | 13e. STREET ADDRESS<br><b>1531 Greenspring Valley Rd</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>THOMAS McETRICK</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELIZABETH DAVEY</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>220-54-6101</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Sr. Catherine D. Cress 1531 Greenspring Valley Rd Stevenson, Md 21153</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br><b>410 -</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ATHEROSCLEROSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                           |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22. I certify that (1) this hospital attended the deceased from <b>Sept. 1980</b> to <b>9-26-1980</b> , that (1) we last saw the deceased alive on <b>Sept. 1980</b> , and that in (any) our opinion death occurred on the date and hour and from the causes stated above. (2) We (did) (could not) view the body after death.   |   |  |   |  |  |
| 22a. SIGNATURE<br><b>[Signature]</b>   |   | DEGREE<br><b>MD</b>  |   | 22c. DATE SIGNED<br><b>9-26-80</b>   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>AUDAN E. WALSH</b>   |   | 22e. ADDRESS<br><b>733 St. Paul BALTO 21202</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |   | 23b. DATE<br><b>9/29/80</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sisters of Notre Dame 1050 York Rd Baltimore</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ILCHESTER Howard Md.</b>  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 30 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(M)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 0 2 2 2 4 7<br>REG. NO.   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |  | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>MARY G. MCEVOY   |  |   |  | 9 24 80   |  |  |  | 4:30A <sub>M</sub>   |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>NOV. 4, 1909  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                         |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GBMC-6701 N. CHARLES ST. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SECRETARY        |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD.  |  |   |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>TOWSON  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSEPH GREGORY   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNA M. RITTER   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |   |  | 16b. SOCIAL SECURITY NO.<br>212-03-1884   |  | 17. INFORMANT ADDRESS<br>MRS. MARY E. SCHOLTES 913 FAIRWAY DR. 21204                 |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for part 1b and 2b)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1749<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) METASTATIC CA OF BREAST<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-24 1980 to 9-24 1980, that (I) (we) lost<br>saw the deceased alive on 9-24 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                          |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>P. J. Patel  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>9/24/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>P. J. PATEL, M.D.   |  |   |  | 22e. ADDRESS<br>GBMC-6701 N. CHARLES ST.  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>SEPT. 27, 80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>DULANEY VALLEY MEM. GDNS.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>COCKEYSVILLE BALTO. MD.                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 30 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>L. H. Brady  |  |  |  |



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ALLIANCE COUNTY

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DATE OF BIRTH

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. GIVE PAGES 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100 TO FUNERAL DIRECTOR; PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |  |  |   |  |   |  |  |  | REG. NO. 30 22248   |  |   |  |  |  |  |  |  |  |  |  |
|--|--|-------------------------|--|--|--|---|--|---|--|--|--|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR<br>DECEASED NAME (TYPE OR PRINT) <b>Donna Lee McManus</b>   |  |                         |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> |  | MONTH DAY YEAR<br><b>9 13 1980</b>  |  | 2b. HOUR AM PM<br><b>5:50 AM</b>  |  |  |  |  |  |  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH (MONTH DAY YEAR)<br><b>9 25 1946</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>33 YRS.</b>                           |  | IF UNDER 1 YR. MONTHS DAYS<br><b>0 0</b>  |  | IF UNDER 24 HRS. HOURS MIN.<br><b>00 00</b>  |  | 7c. DATE PRONOUNCED DEAD<br><b>9 13 1980</b>  |  | 7d. HOUR AM PM<br><b>5:50 AM</b>  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>  |  |   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>7831 St. Boniface Lane</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Asst. Manager</b>   |  |  |  | 12b. KIND OF BUSINESS<br><b>Fashion Bug</b>   |  |   |  |  |  |  |  |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |                         |  | 13b. COUNTY<br><b>Baltimore</b>  |  |   |  | 13c. CITY OR TOWN<br><b>Dundalk</b>   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |  |   |  | 13e. STREET ADDRESS<br><b>7831 St. Boniface Lane</b> |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Donald W. Eberhardt, Sr.</b>   |  |                         |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Dorothy E. Middleditch</b> |  |   |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>218-42-4889</b>       |  |  |  | 17. INFORMANT<br><b>Rt. 1, Box 190-13 26330 Ronald J. McManus-Bridgeport W. VA</b> |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Smoke inhalation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                         |  |  |  |   |  |   |  |  |  |   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Smoke inhalation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                         |  |  |  |   |  |   |  |  |  |   |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |   |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>4:50xx 9 13 1980</b>  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>Subject caught in house fire</b>  |  |  |  |   |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>   |  |   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE<br><b>7831 St. Boniface Ln., Dundalk, Baltimore, Md.</b>  |  |  |  |   |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                         |  |  |  |   |  |   |  |  |  |   |  |   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><i>Virginia L. Dolan</i>   |  |                         |  | M.D. <b>Assistant</b>  |  |   |  | MEDICAL EXAMINER  |  |  |  | DATE SIGNED <b>9/13/80</b>  |  |   |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>  |  |                         |  | ADDRESS<br><b>111 Penn Street</b>  |  |   |  |   |  |  |  |   |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>9/16/80</b>  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>   |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR <b>Duda-Ruck, Inc.</b><br>NAME ADDRESS<br><b>7922 Wise Avenue, Dundalk, MD 21222</b>  |  |                         |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 16 1980</b>   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert McCreedy</i>  |  |   |  |  |  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 42 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   | 8 0 2 2 2 4 9  |  |
|--|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>EDWARD S. MEREDITH</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9/14/80</b>  |   | 2b. HOUR<br><b>5:00P</b>   |  |
| 3 SEX<br><b>MALE</b>   | 4 RACE<br><b>WHITE</b>   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUGUST 21, 1919</b>  |   | 6 AGE (IN YEARS (LAST BIRTHDAY))<br><b>61</b> YRS.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |  |
| 10 CITY OR TOWN OF DEATH<br><b>TOWSON</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC-- 6701 N. CHARLES ST.</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALES</b> |  | 12b KIND OF BUSINESS OR INDUSTRY   |
| 13a STATE<br><b>MD.</b>  |  | 13b COUNTY   | 13c CITY OR TOWN<br><b>BALTIMORE</b>  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br><b>415 WOODLAWN RD. 21210</b>                      |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN T. MEREDITH</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MINA SIMPSON</b>   |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b SOCIAL SECURITY NO.<br><b>WW2 216-12-2166</b>  |   | 17 INFORMANT ADDRESS<br><b>KATHRYN J. MEREDITH 415 WOODLAWN RD. 21210</b>                      |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CA OF LARYNX WITH LUNG METASTASIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>9/9/80</b> to <b>9/14/80</b> , that (I) (we) lost saw the deceased alive on <b>9/14/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death. |  |  |   |  |  |
| 22b SIGNATURE<br><i>Juan M. Andrade</i>  |  | DEGREE   |   | 22c DATE SIGNED  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JUAN M. ANDRADE MD</b>  |  | 22e ADDRESS<br><b>GBMC---6701 N. CHARLES ST.</b>   |   |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b DATE<br><b>SEPT. 17, 1980</b>  | 23c NAME OF CEMETERY OR CREMATORY<br><b>MORELAND MEMORIAL PK.</b>               |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>TOWSON BALTIMORE MD.</b> |
| 24 FUNERAL DIRECTOR NAME<br><b>MITCHELL-WIEDEFELD HOME</b>   |  | ADDRESS<br><b>6500 YORK RD.</b>  |   | 25. DATE OF DEATH BY REGISTERED MEDICAL EXAMINER<br><b>SEP 19 1980</b>                         |  |

085 1928

212AT2AT34 2403 171W-224V-43 50

03/41/7

900 :

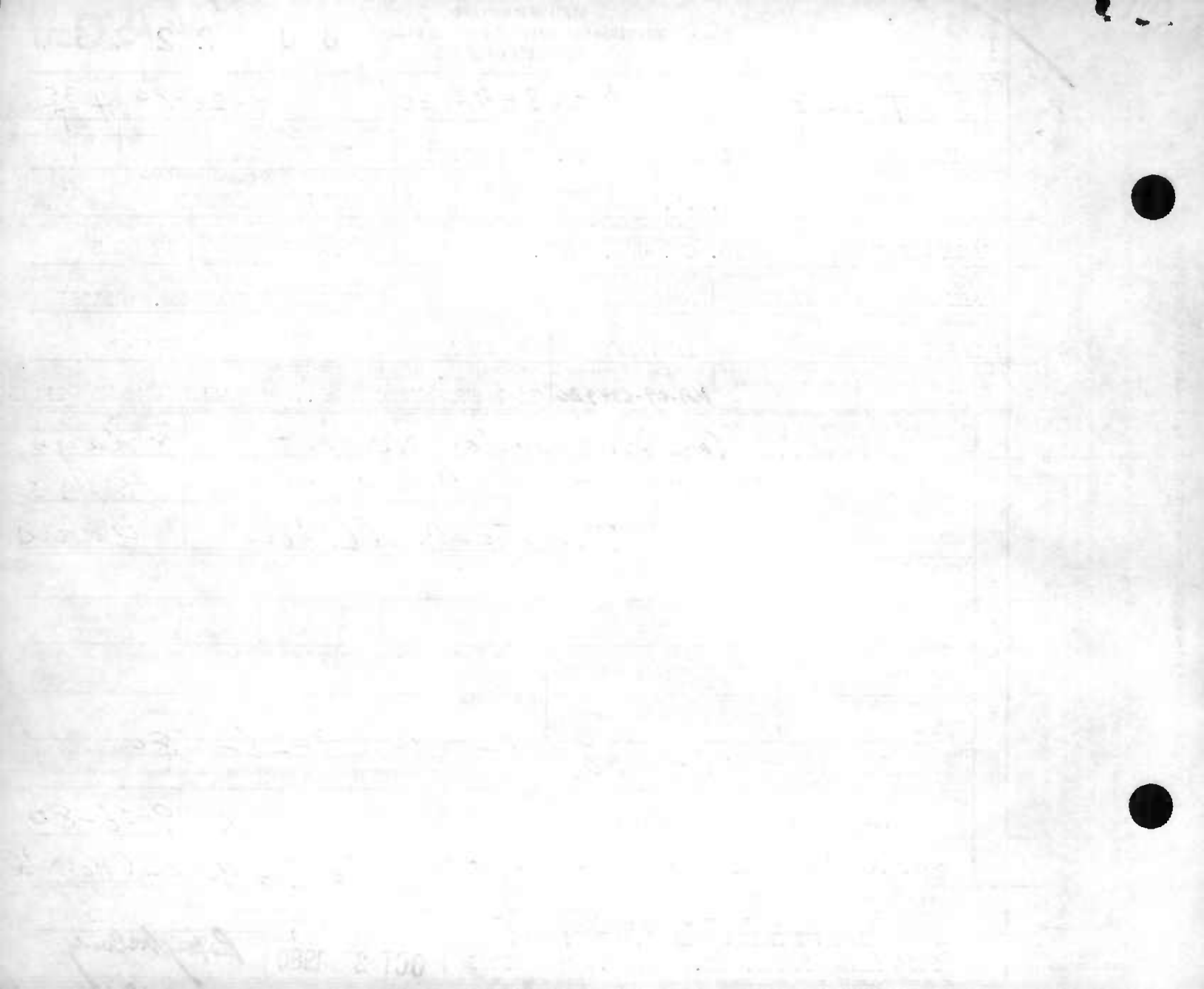
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 80 22250<br>REG. NO.   |  |   |  |   |  |
|--|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>TILLIE MERSE RACEO</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>9-26-80</b>  |  |   |  | 2b. HOUR <b>4 35 P.M.</b>   |  |
| 3 SEX <b>FEMALE</b>  |  | 4 RACE <b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>OCT. 11, 1901</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br>IF UNDER 24 HRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>                  |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTO. CO. GEN. HOSP.</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>    |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  |  |   |  |   |  |
| 13a. STATE <b>MARYLAND</b>   |  | 13b. COUNTY <b>BALTIMORE</b>  |  | 13c. CITY OR TOWN <b>RANDALLSTOWN</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>3607 STONEYBROOK RD. #21133</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>RABBI ABRAHAM LAVINSKY</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LENA UNKNOWN</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  |   |  | 16b. SOCIAL SECURITY NO <b>16A-09-6349 B6</b>  |  | 17. INFORMANT <b>MR. RONALD MESSLER</b>   |  |   |  |
| 3607 STONEYBROOK RD., RANDALLSTOWN, MD 21133   |  |   |  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b><br><b>2500</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypertensive heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes mellitus</b> |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 days</b><br><b>years</b><br><b>years</b>                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-18-80</b> to <b>9-26-80</b> , that (I) (we) lost <b>1980</b> above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>Soonchul Hong</b>  |  |   |  | DEGREE <b>ATTENDING PHYSICIAN</b> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                          |  |   |  | 22c. DATE SIGNED <b>9-26-80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SOON CHUL HONG</b>  |  |   |  | 22e. ADDRESS <b>Baltimore County General Hospital</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>9-28-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>MIKRO KODESH-BETH ISRAEL</b>   |  | 23d. LOCATION CITY OR TOWN <b>BALTIMORE</b>                                       |  | COUNTY <b>MD</b> STATE  |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b>   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 2 1980</b>                                   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |
| 6010 REISTERSTOWN RD., BALTO., MD 21215  |  |   |  |  |  |   |  |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8022251

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Virginia C. Messina</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 28, 1980</b>                                |  | 2b. HOUR<br><b>2:30 PM</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 1, 1983</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Italy</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. County</b> MD.                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Garrison</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Garrison Valley Nursing Home</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |  |  |
| 13a. STATE<br><b>Md.</b>   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Fullerton</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>Sunrise Mobile Home Village</b>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Pettara</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna -</b>                                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220-03-4591</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Peter S. Messina 3429 E. Northern Pkway</b>           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASCVD AND ARYTHMIA</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>YES</b>   |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>ANEMIA</b>   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>5 MAY</b> , 19 <b>80</b> to <b>26 SEPT</b> , 19 <b>80</b> , that <del>we</del> (we) last saw the deceased alive on <b>26 SEPT</b> , 19 <b>80</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <b>(did not)</b> view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>9-28-80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Arthur M. Lebson MD</b>  |  | 22e. ADDRESS<br><b>3640 Fords Lane Baltimore, Md.</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>Oct. 1, 1980</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Most Holy Redeemer</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 30 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE<br>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 0 2 2 2 5 2<br>REG. NO.   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BERTHA C. MILLER</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>SEPT 30 '80</b> 2b. HOUR <b>9 PM</b>  |  |   |  |
| 3. SEX <b>FEMALE</b>   |  | 4. RACE <b>White CAUCASION</b>   |  | 5. DATE OF BIRTH <b>August 17, 1894</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS. MONTHS DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Rossville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MANOR CARE ROSSVILLE</b> |  | 12a. USUAL OCCUPATION (BE OF WORK, IF MOST OF WORKING LIFE) <b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13e. STREET ADDRESS   |  |   |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS <b>17517 Falls Road; Upperco, Md.</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Conrad Ziegler</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Schneider</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>213-05-6504D</b>   |  | 17. INFORMANT ADDRESS <b>William O. Miller, Jr. 17517 Falls Road</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <b>Acute Myocardial infarction.</b>  |  |  |  |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardio-vascular disease</b>   |  |  |  |   |  |   |  |
| (c)  |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Parkinson's disease; Hematuria, Asthmatic Bronchitis.</b>  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>3/19/ 19 80</b> P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>3/19/ 19 80</b> to <b>9/30/ 19 80</b> , that (we) lost saw the deceased alive on <b>9/30/ 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>[Signature]</b>  |  |  |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>9/30/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KHIN M. TUN</b>   |  |  |  | 22e. ADDRESS <b>2110 pot spring Road Balto md 21093</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>10-3-1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pikesville Maryland</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b>  |  |  |  | ADDRESS <b>1050 York Road Towson, Maryland</b>  |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 3 1980</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                           |  |

MEDICAL CERTIFICATION



*[Faint, mostly illegible text and markings covering the main body of the page. Some words like "RECEIVED" and "OFFICE" are faintly visible.]*

*[Handwritten signature or initials in the bottom left corner.]*

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 2 2 5 3

|   |  |                  |  |   |  |   |  |   |  |                               |  |   |  |           |  |  |  |                     |  |
|---|--|------------------|--|---|--|---|--|---|--|-------------------------------|--|---|--|-----------|--|--|--|---------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>JUNE    |  | MIDDLE<br>M.  |  | LAST<br>MILLER                                |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED  |  |                               |  | MONTH<br>9  |  | DAY<br>12 |  | YEAR<br>1980                                       |  | 2b. HOUR<br>1:04 PM |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>06 04 05  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>75 YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>9 12 1980   |  |           |  | 2d. HOUR<br>1:04 PM                                |  |                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PENNSYLVANIA   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |           |  |  |  |                     |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO. HIGHLANDS   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3021 VIRGINIA AVENUE, 21227 |  |   |  |   |  |                               |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CLERK                          |  |           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>MONTGOMERY    |  |                     |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                  |  |   |  |   |  |   |  |                               |  |   |  |           |  |  |  |                     |  |
| 13a. STATE<br>MARYLAND  |  |                  |  | 13b. COUNTY<br>BALTIMORE  |  |   |  | 13c. CITY OR TOWN<br>BALTO. HGLDS.  |  |                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |           |  | 13e. STREET ADDRESS<br>3021 VIRGINIA AVENUE, 21227 |  |                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN   |  |                  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>JENNIE HARMON  |  |                               |  |   |  |           |  |  |  |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO   |  |                  |  | (IF YES, GIVE WAR OR DATES)   |  |   |  | 16b. SOCIAL SECURITY NO.<br>220-12-5059   |  |                               |  | 17. INFORMANT<br>ADDRESS<br>JOSEPH R. GUTKOSKA 3021 VIRGINIA AVE.                               |  |           |  |  |  |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ASCVD<br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) ALZHEIMER'S DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>YEARS<br>YEARS  |  |                  |  |   |  |   |  |   |  |                               |  |   |  |           |  |  |  |                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDIOTIN GIVEN IN PART 1 (a).   |  |                  |  |   |  |   |  |   |  |                               |  |   |  |           |  |  |  |                     |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |                               |  |   |  |           |  |  |  |                     |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |                  |  |   |  |   |  |   |  |                               |  |   |  |           |  |  |  |                     |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |                               |  |   |  |           |  |  |  |                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |                               |  |   |  |           |  |  |  |                     |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |   |  |   |  |                               |  |   |  |           |  |  |  |                     |  |
| ACTUAL SIGNATURE<br>E. P. Williamson  |  |                  |  | TITLE (SPECIFY)<br>M.D. Deputy  |  |   |  | MEDICAL EXAMINER  |  |                               |  | DATE SIGNED<br>9/12/80  |  |           |  |  |  |                     |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>E. P. Williamson  |  |                  |  | ADDRESS<br>5530 BALTO NAT'L PKE 21228   |  |   |  |   |  |                               |  |   |  |           |  |  |  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |                  |  | 23b. DATE<br>09-15-80   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>NEW CATHEDRAL   |  |                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MARYLAND                           |  |           |  |  |  |                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME, INC.  |  |                  |  | ADDRESS<br>4107 WILKENS AVE.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 15 1980  |  |                               |  | 25b. REGISTRAR'S SIGNATURE<br>Dorothy McCreedy  |  |           |  |  |  |                     |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 0 2 2 2 5 4<br>REG. NO.  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Samuel Lester Mills, Jr.  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>September 1, 1980  |  | 2b. HOUR<br>4:30 PM  |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>April 5, 1915  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.   |  |
| 10 CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1205 Providence Road |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>District Manager  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Universal Match   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Towson  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Samuel L. Mills, Sr.  |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Lillian Byrd  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO<br>WW II 230-03-2937   |  | 17 INFORMANT ADDRESS<br>Mrs. Ruby C. Mills Same as #13.  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Metastatic Squamous Cell Carcinoma of the lung</i><br>1639<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4/12/1979</i> to <i>8/21/1980</i> , that (I) (we) lost saw the deceased alive on <i>8/21/1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Davis M. Hahn</i>  |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  | 22c. DATE SIGNED<br>9/2/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Davis M. Hahn, MD  |  |  |  | 22e. ADDRESS<br>Good Samaritan Hospital Baltimore, Maryland  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  | 23b. DATE<br>Sept. 2, 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Crematory  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland   |  |
| 24 FUNERAL DIRECTOR NAME<br>Ruck Towson Funeral Home, Inc.  |  | ADDRESS<br>1050 York Road  |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 9 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><i>L. H. Hahn</i>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM - 16 50M 1/76  
(VR A 15 (4))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  | 8 0 2 2 2 5 5 |
|--|--|--|--|---|--|--|--|---|--|---------------|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |  |  |   |  | REG. NO.      |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>SELINA E. MILLS   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>09 05 80                   |  |  | 2b. HOUR<br>6:55 PM   |  |               |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 13 97  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 74 HRS HOURS MIN.   |  |               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD  |  |   |  |               |
| 10. CITY OR TOWN OF DEATH<br>CATONSVILLE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FOREST HAVEN NURSING HOME |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SEAMSTRESS   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>CLOTHING   |  |               |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |  |  |   |  |               |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>HOWARD  |  | 13c. CITY OR TOWN<br>ELLICOTT CITY  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br>2934 SOUTHVUE ROAD   |  |               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CHARLES O. KEARNEY   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARTHA CROSBY |  |  |   |  |               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  |  |  | 16b. SOCIAL SECURITY NO.<br>220-12-5386   |  | 17. INFORMANT ADDRESS<br>MILDRED K. MILLS 2934 SOUTHVUE ROAD   |  |   |  |               |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>3448 IMMEDIATE CAUSE (a) Pneumonia<br>DUE TO, OR AS A CONSEQUENCE OF (b) Steel-Richard's del.<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) 4 years<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |  |   |  |               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br>Chronic teleostea h.d. dis.  |  |  |  |   |  |  |  |   |  |               |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |               |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |               |
| 22a. I certify that (I) this hospital attended the deceased from 9/4 to 9/15, 1980 that (I) was lost<br>saw the deceased alive on 9/4, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.  |  |  |  |   |  |  |  |   |  |               |
| 22b. SIGNATURE<br>Christian S. Mass, M.D.  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>9/6/80  |  |               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHRISTIAN S. MASS, M.D.   |  |  |  |   |  | 22e. ADDRESS<br>HOWARD COUNTY MEDICAL CENTER   |  |   |  |               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>09-09-80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>LOUDON PARK   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MARYLAND  |  |   |  |               |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 8 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>Anthony McCreedy   |  |   |  |               |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 0 2 2 2 5 6<br>REG. NO.  |  |   |  |   |  |
|---|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |  | 2b. HOUR  |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Dr. Walter Richard MINAHAN (D.D.S.)  |  |   |  | September 20, 1980   |  |   |  | 1:35 p.m.   |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>11/16/1906   |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS.<br>73 yrs.                                    |  | 7 IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                       |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Rossville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Dentist          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Medicine   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Balto. 13c. CITY OR TOWN Dundalk   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br>2516 Liberty Parkway 21222                                 |  |   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Walter R. Minahan   |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Margaret McGovern   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  | 16b. SOCIAL SECURITY NO<br>217.38.3875  |  | 17 INFORMANT ADDRESS<br>Mae J. Minahan--Wife--Same as 13e  |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Apnea; Cerebrovascular Accident<br>436-<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 12, 1980, to September 20, 1980, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on September 20, 1980, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE P. Befabis   |  |   |  | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  |   |  | 22c. DATE SIGNED 9/20/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Befabis  |  |   |  | 22e. ADDRESS 9000 Franklin Square Drive 21237  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE 9/23/1980   |  | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland                        |  |   |  |
| 24 FUNERAL DIRECTOR NAME Walter Brooks Bradley, ;Inc., Dundalk, Md. 21222   |  |   |  | 25. DATE REC'D. BY REGISTRAR SEP 25 1980   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |                            |  |   |
|---|--|--|--|---|--|--|----------------------------|--|---|
| 1 - FOR<br>STATE<br>REGISTRAR   |  | 7 0 2 2 2 5 7  |  |   |  | REG. NO.   |                            |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>EDITH MA Y MOFFAT  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>9 16 80                    |  |                            | 2b. HOUR<br>9:05 P. M.   |   |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>2 <sup>ND</sup> 14 <sup>TH</sup> 06 <sup>TH</sup>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74  |                            | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>ENGLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO COUNTY MD                              |                            |  |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. JOSEPH HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>PHONE OPERATOR   |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br>BALTO. CITY   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD  |  |  |  |   | 13b. COUNTY<br>BALTO   |  | 13c. CITY OR TOWN<br>BALTO |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ENOCH BICKERSTAFFE  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>EDITH JOHNSON |  |                            |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>212-34-8044  |  | 17. INFORMANT ADDRESS<br>EDITH E. SWOBODA 420 DUNKIRK RD. 21212   |  |  |                            |  |   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic cardiovascular disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hr |  |  |  |   |  |  |                            |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Aortic stenosis</u>   |  |  |  |   |  |  |                            |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                            |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                            |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/12/80</u> 19 <u>80</u> to <u>9/16/80</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>9/17/80</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |                            |  |   |
| 22b. SIGNATURE<br><u>James Biddison, MD</u>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |                            | 22c. DATE SIGNED<br>9/17/80  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JAMES BIDDISON   |  |  |  | 22e. ADDRESS<br>1900 E. NORTHERN PKWY.  |  |  |                            |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>9/20/1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>NEW CATHEDRAL CEM.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD                           |                            |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>MITCHELL-WIEDEFELD HOME   |  |  |  | ADDRESS<br>6500 YORK RD. 21212  |  | 25. DATE REC'D. BY REGISTRAR<br>SEP 22 1980  |                            | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |   |

STATE OF MARYLAND  
DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |   |  |  | REG. NO.<br>80 22258              |  |  |
|---|--|---|--|---|--|--|---|--|--|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR  |  |   | 1. DECEASED NAME<br>FIRST MIDDLE LAST<br>ARMAND JOSEPH MORIN SR        |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>09/20/80   |  |  | 2b. HOUR<br>7:50AM                |  |  |
| 3. SEX<br>M   |  | 4. RACE<br>W  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5/14/08   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.                       |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                      |  | 7. IF UNDER 24 HRS.<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MASS   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.     |   |  |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>G.B.M.C. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>STEEL             |  |                                   |  |  |
| 13a. STATE<br>MD.   |  |   | 13b. COUNTY<br>BALTO   |   | 13c. CITY OR TOWN<br>ESSEX   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>61512 STEMMERS RUN RD   |                                   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSEPH MORIN  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>JOSEPHINE ROCHETTE    |   |  |  |   |  |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>UNK   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>05-07-7793  |   | 17. INFORMANT<br>FLORIDA MORIN   |  |   |  |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) CARDIO PULMONARY RENAL FAILURE<br>1579<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) PANCREATIC CANCER<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 DAY<br>3 WEEKS |  |   |  |   |  |  |   |  |  |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |   |  |  |                                   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |                                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |                                   |  |  |
| 22a. I certify that (this hospital) attended the deceased from 09/02/1980 to 09/20/1980, that (we) last saw the deceased alive on 09/20/1980, and that in (our) opinion death occurred on the date and hour and from the causes stated above (X we) did not view the body after death.  |  |   |  |   |  |  |   |  |  |                                   |  |  |
| 22b. SIGNATURE<br>DR. C. S. HU  |  |   |  |   | 22c. DATE SIGNED<br>9/20/80  |  |   |  |  |                                   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  |   | 22e. ADDRESS<br>G.B.M.C. 6701 N. CHARLES ST. BALTO MD 21204'                   |  |   |  |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |   | 23b. DATE<br>9/23/80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>MEADOWRIDGE                              |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO MD |  |                                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>J.G. CONNELLY 300 MACE  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>SEP 24 1980                                   |  | 25b. REGISTRAR'S SIGNATURE<br>Mickey McCreedy   |  |  |                                   |  |  |

ANNOUNCING JOSEPH MORIN SR. 00/20/80 17:50A

BALTIMORE COUNTY

BALTIMORE

CARDIOPULMONARY RENAL FAILURE

PANCREATIC CANCER

3 WEEKS

1 DAY

XX 00/20/80 XX 00/20/80 XX 00/20/80

DR. C. S. HU G.B.H.C. 6701 P. CHARLEST TOTTU MD

279 S. BALDWIN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-357-1300.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 0 2 2 2 5 9<br>REG. NO.  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 1. DECEASED NAME FIRST MIDDLE LAST<br>Hester A. MORRIS   |  |   |  |
| 2a. DATE OF DEATH MONTH DAY YEAR<br>September 14, 1980  |  | 2b. HOUR<br>9:35 p.m.   |  | 3. SEX<br>Female   |  | 4. RACE<br>White  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br>2/16/1891  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>89 yrs.  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  | 10. CITY OR TOWN OF DEATH<br>Rossville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland |  | 13b. COUNTY<br>Baltimore  |  |
| 13c. CITY OR TOWN<br>Dundalk  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>7236 Sollers Point Rd. 21222  |  | 14. FATHER'S NAME FIRST MIDDLE LAST<br>John R. Harper   |  |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Donahue  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                      |  | 16b. SOCIAL SECURITY NO.<br>212.46.6234  |  | 17. INFORMANT ADDRESS<br>Eleanor K. Harper---Same as 13e  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio-respiratory Arrest<br>4280<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF Congestive Heart Failure<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Age; Cerebrovascular Accident; Coma   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                          |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from August 26, 1980, to September 14, 1980, that (we) last saw the deceased alive on September 14, 1980, and that in (we) (did) view the body after death.   |  |   |  |  |  |   |  |
| 22b. SIGNATURE OF PHYSICIAN<br>Raul Masvidal M.D.   |  |   |  | DEGREE<br>M.D.   |  | 22c. DATE SIGNED<br>9-14-80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Raul Masvidal M.D.   |  |   |  | 22e. ADDRESS<br>9000 Franklin Square Drive 21237   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>9/18/1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Heart of Jesus  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Dundalk Maryland   |  |
| 24. FUNERAL DIRECTOR NAME<br>Walter Brooks Bradley, -Inc., Dundalk, Md. 21222   |  |   |  | 25a. DATE REC'D BY REGISTRAR<br>SEP 19 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |





Released by Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

BP \_\_\_\_\_

DHMM - 16 50M 7/77  
(VR A 15 (4))TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 7 0 2 2 2 6 0   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>RUTH H. NORMAN   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>09 25 80  |  | 2b. HOUR<br>02:10 <sup>AM</sup>  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>JAN. 28, 1898  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER                      |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>RIDERWOOD  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>Acorn Hill Lane   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>CHARLES F. MILLER   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>VIRGIE J. HARP  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>219-10-3163   |  | 17. INFORMANT ADDRESS<br>Eleanor M. Barnhart Same  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Concise - Respiratory arrest.</u><br>733/ DUE TO, OR AS CONSEQUENCE OF <u>UNEXPLAINED - Chronic Aortic Pathology</u><br>(b) DUE TO, OR AS CONSEQUENCE OF <u>Pathological fx RIGHT HIP</u><br>(c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>09-25-80</u> 19 <u>80</u> to <u>09-25-80</u> 19 <u>80</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Sept. 25, 1980</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> not view the body after death. |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE <u>M. Pena</u>  |  |   |  | DEGREE  |  |   |  | 22c. DATE SIGNED<br>09-25-80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Max N. Pena, M.D.   |  |   |  | 22e. ADDRESS<br>St. Joseph Hospital   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>SEPT. 27, 80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MEADOW BRANCH CEM.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>WESTMINSTER CARROLL MD.                              |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>MITCHELL-WIEDEFELD HOME   |  |   |  | ADDRESS<br>6500 YORK RD. 21212  |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 30 1980  |  |  |  |

SEP 30 1980  
 [Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 0 2 2 2 6 1<br>REG. NO.   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR<br>George R. Morrison   |  |  |  | 2a. DATE OF DEATH<br>September 15, 1980   |  |   |  | 2b. HOUR<br>9:15P M  |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White  |  | 5. DATE OF BIRTH<br>Feb. 5, 1913  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                     |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>612 Valley Lane |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Self Employed |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction  |  |
| 13a. STATE<br>Maryland   |  |  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Towson   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14 FATHER'S NAME<br>Robert Morrison  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>Florence Robinson   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>182-03-6926   |  | 17. INFORMANT ADDRESS<br>Mrs Mildred E. Morrison, Same As #13e  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypertensive Atherosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Cardiovascular Disease</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 77 to 9/15, 19 80, that (I) (we) last saw the deceased alive on 9/15, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Charles J. Blazek M.D.   |  |  |  | DEGREE<br>M.D.  |  |   |  | 22c. DATE SIGNED<br>9/16/80  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Charles Blazek, M.D.  |  |  |  | 22f. ADDRESS<br>1116 St. Paul Street Baltimore, Maryland  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  | 23b. DATE<br>Sept. 16, 1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Crematory   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                 |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc. Towson, Md. 21204   |  |  |  | 24b. ADDRESS<br>1050 York Road  |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 18 1980                                      |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |  |   |  |  |   |  | 8022262 |  |
|--|--|---|---|--|---|--|--|---|--|---------|--|
| FOR<br>STATE<br>REGISTRAR  |  |   | REG. NO.  |  |   |  |  |   |  |         |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>MARY DORAN MOUNT</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>9-26-80</i> |  |   | 2b. HOUR<br><i>8:28 AM</i>   |  |   |  |         |  |
| 3. SEX<br><i>female</i>  | 4. RACE<br><i>white</i>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>11 28 1882</i>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>97</i> YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                                   |  | IF UNDER 24 HRS                                 |  |         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>TN</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD   |   |  |  |   |  |         |  |
| 10. CITY OR TOWN OF DEATH<br><i>Randallstown</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Randallstown Convalescent Center</i> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>School teacher</i>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>FL Schools</i>                     |  |   |  |         |  |
| 13a. STATE<br><i>TN</i>  |  | 13b. COUNTY<br><i>Davidson</i>  | 13c. CITY OR TOWN<br><i>Nashville</i>                 | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 13e. STREET ADDRESS<br><i>2209 Abbott Martin Drive</i>                    |  |  |   |  |         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Benjamin Watson Bennett</i>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><i>Margaret Green</i>   |   |  |   |  |  |   |  |         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><i>-</i>  |   | 17. INFORMANT<br>ADDRESS<br><i>Mrs. Edgar Legum<br/>3402 Shelburne Rd., Baltimore, MD 21208</i>  |   |  |  |   |  |         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>  |  |   |   |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |         |  |
| 410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>ASCC</i>  |  |   |   |  |   |  |  |   |  |         |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>coronary artery disease</i>   |  |   |   |  |   |  |  |   |  |         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |   |   |  |   |  |  |   |  |         |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |   |  |         |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |   |  |         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9/20</i> <i>2-20</i> 19 <i>80</i> , to <i>9/26</i> 19 <i>80</i> , that (I) (we) lost<br>saw the deceased alive on <i>9/20</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |   |  |  |   |  |         |  |
| 22b. SIGNATURE<br><i>Daniel Wilfson</i>  |  | DEGREE  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><i>9/26/80</i>   |  |   |  |         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Daniel Wilfson, MD</i>   |  | 22e. ADDRESS<br><i>3502 W. Rogers Ave., Baltimore, MD 21215</i>   |   |  |   |  |  |   |  |         |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Entombment</i>  |  | 23b. DATE<br><i>9/29/80</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Woodlawn Mausoleum</i>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Nashville Davidson TN</i> |  |   |  |         |  |
| 24. FUNERAL DIRECTOR <i>Loring Byers Funeral Directors, P.A.</i>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR <i>SEP 30 1980</i>   |   | 25b. SIGNATURE<br><i>[Signature]</i>                                       |  |   |  |         |  |
| 8728 Liberty Rd., Randallstown, MD 21133   |  |   |   |  |   |  |  |   |  |         |  |

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D.C.



*[Faint, mostly illegible handwritten text and lines, possibly a ledger or record sheet.]*

*[Handwritten signature or initials.]*

0821 08932



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |   |  |  |  |                                | REG. NO. 80 22263   |  |
|---|--|---|--|--|---|--|--|--|--------------------------------|---|--|
| 1. FOR STATE REGISTRAR  |  |   | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>FRANK J. MURPHY</b> |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>9/21/80</b> |  | 2b. HOUR MIN.<br><b>10:30P</b> |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12 29 06</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>73</b>                                    |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.             |                                |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                  |  |  |                                |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC---6701 N. CHARLES ST.</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck Driver</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>                    |                                |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS                                |  |                                |   |  |
| 13a. STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Woodlawn</b>   |   | 13e. STREET ADDRESS<br><b>1454 Barrett Road</b>                                      |  |  |                                |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>James P. Murphy</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Elizabeth A. Bowen</b>  |   |  |  |  |                                |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]<br><b>Yes WW2</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>217-03-9146</b>   |   | 17. INFORMANT<br><b>James B. Murphy</b>  |  | ADDRESS<br><b>300 N. Beechwood Avenue Baltimore, Md. 21228</b>         |                                |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>RESPIRATORY ARREST</b><br>IMMEDIATE CAUSE (a) _____<br><b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA OF LUNGS WITH METASTASIS</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. |  |   |  |  |   |  |  |  |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |  |   |  |  |  |                                |   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>8/9 80</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |                                |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |  |  |                                |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/9 80</b> to <b>9/21 80</b> , that (I) (we) last saw the deceased alive on <b>9/21 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |   |  |  |  |                                |   |  |
| 22b. SIGNATURE<br><b>Apparao N.V. Vanguri</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>     |   |  |  | 22c. DATE SIGNED   |                                |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>APPARAO N.V. VANGURI</b>  |  |   |  | 22e. ADDRESS<br><b>GBMC---6701 N. CHARLES ST</b>   |   |  |  |  |                                |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>9/24/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                 |  |  |                                |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Witzke Funeral Home of Catonsville</b>  |  |   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 22 1980</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                       |                                |   |  |
| 1630 Edmondson Ave Catonsville, Maryland 21228  |  |   |  |  |   |  |  |  |                                |   |  |



UNITED STATES

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D.C.

DEPARTMENT OF JUSTICE

UNITED STATES OF AMERICA



1961

1961

UNITED STATES OF AMERICA

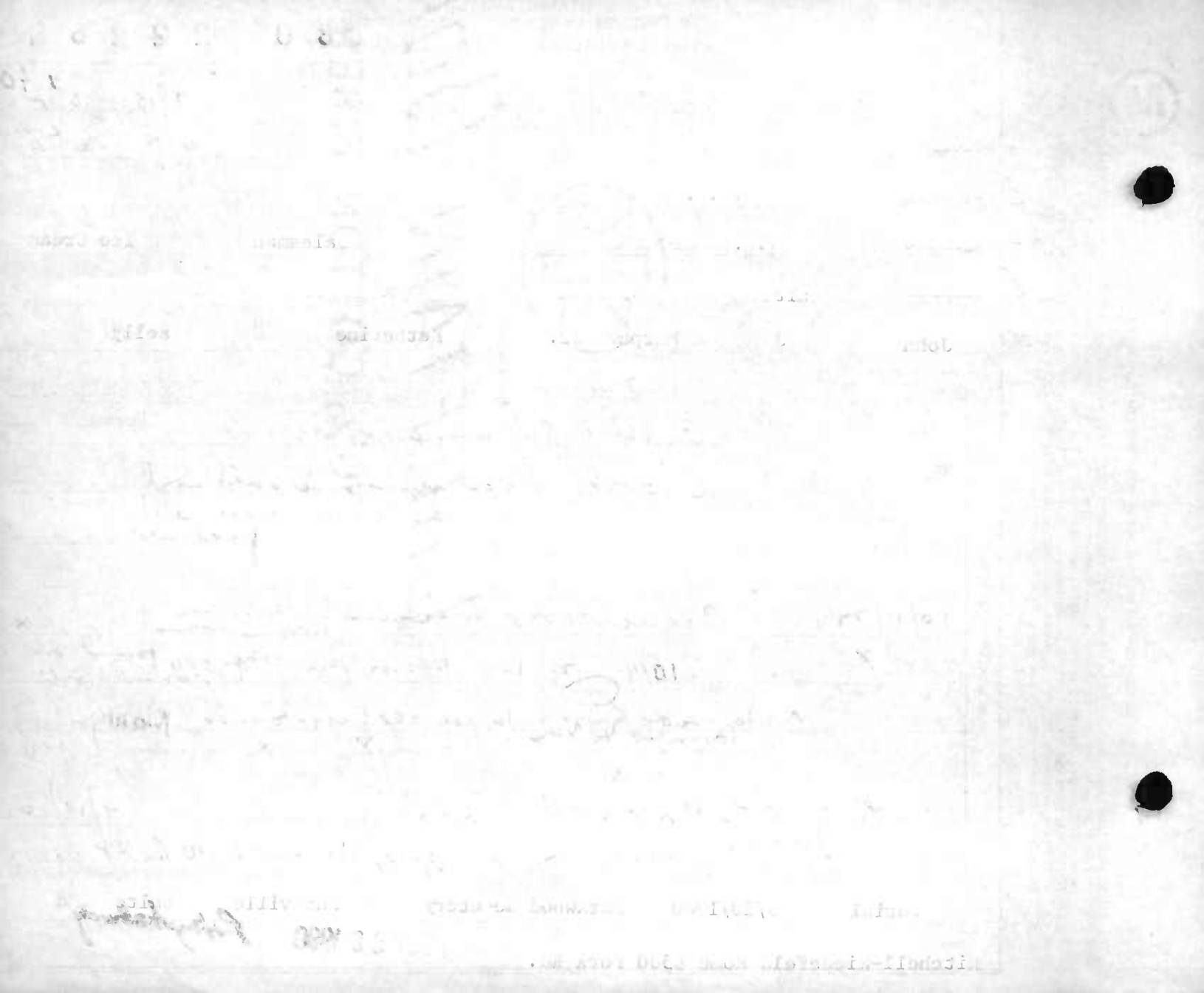
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UNITED STATES OF AMERICA

UNITED STATES OF AMERICA







Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  | 8 0 2 2 2 6 5                                |  |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |   |  |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| MERLE   |  | LORRAINE   |  | MURRAY  |  |  |  | September 21, 1980  |  | 4:55p M                                      |  |
| 3 SEX   |  | 4 RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS HOURS MIN                    |  |
| Female  |  | White  |  | July 4, 1910  |  | 70 YRS   |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  | MD   |  |
| Maryland  |  | U.S.A.   |  |   |  | Baltimore County   |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |  |  |
| Rossville   |  | Franklin Square Hosp.  |  | Waitress  |  | Restaurant   |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS   |  |  |  |
| Maryland  |  | Baltimore  |  | Essex   |  |  |  | 5 Bret Court  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |   |  |  |  |   |  |  |  |
| Walter H. Thompson  |  | Emma E. Coe  |  |   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT ADDRESS  |  |  |  |   |  |  |  |
| No  |  | 220-09-88960   |  | Walter Reichert, 2900 Onyx Rd. 21234  |  |  |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive & Arteriosclerotic Cardio-vascular Disease with old & recent Myocardial Infarction  |  |  |  |   |  |  |  |   |  |  |  |
| 410 - CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST   |  |  |  |   |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |  |  |   |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 20, 19 80, to September 21, 19 80, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on September 21, 19 80, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE P. Bafanis   |  | DEGREE MD  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>              |  | 22c. DATE SIGNED 9/21/80   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. Bafanis  |  | 22e. ADDRESS 9000 Franklin Square Drive 21237  |  |   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE Sept. 25, 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY Parkwood   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  | Parkville, Balto., Md.  |  |  |  |
| 24. FUNERAL DIRECTOR ROBERT C. ALTENBURG FUNERAL HOME, INC.   |  | 25a. DATE REC'D. BY REGISTRAR SFP 24 1980  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |   |  |  |  |
| 6009 Harford Rd., Balto., Md. 21214   |  |  |  |   |  |  |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |   |   |  |  | REG. NO. 80 22266 |  |
|---|--|---|--|---|---|---|---|--|--|-------------------|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |   |   |   |  |  |                   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>CHESTER (JESS) MUSZEL</b>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>September 1 1980</b>       |   |   | 2b. HOUR<br><b>4:00 A.M.</b>   |  |                   |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>6 29 1910</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>70 YRS.</b>          |   | 7. IF UNDER 1 YEAR 8 UNDER 24 HRS.   |  |                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>POLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>               |   |  |  |                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Baltimore Medical Center</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>BAKERY</b>    |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SELF</b>   |  |                   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY<br><b>MARYLAND</b>  |  |   |  |   | 13d. CITY OR TOWN<br><b>BALTIMORE</b>                             |   | 13e. STREET ADDRESS<br><b>1208 S. CLINTON ST.</b> |  |  |                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JOHN MUSZEL</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>HELEN MUCHLA</b> |   |   |  |  |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218 36 7090</b>  |  | 17. INFORMANT ADDRESS<br><b>EDWARD MUSZEL 3406 DILLON ST.</b>   |   |   |   |  |  |                   |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Carcinoma of lung</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                |  |   |  |   |   |   |   |  |  |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Chronic cholecystitis with peritonitis; peptic ulcer disease</b>  |  |   |  |   |   |   |   |  |  |                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |  |  |                   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |   |   |  |  |                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>August 25</b> , 19 <b>80</b> , to <b>Sept. 1</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>Sept. 1</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |   |   |  |  |                   |  |
| 22b. SIGNATURE OF PHYSICIAN<br><b>John E. Adams</b>   |  |   |  |   |   |   |   | 22c. DATE SIGNED<br><b>Sept. 1, 1980</b>   |  |                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John E. Adams, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>6701 N. Charles Street, Towson, Md. 21204</b>  |   |   |   |  |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>9/5/1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross PNCC</b>  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE Co. MD.</b>               |   |  |  |                   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>RAYMOND L. KACZOROWSKI</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 4 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>                             |   |  |  |                   |  |

